GROWING TOGETHER IN THE HEALING MINISTRY

New Strategies for Asian Christians 2000 A.D.

CHRISTIAN CONFERENCE OF ASIA
DEVELOPMENT AND SERVICE

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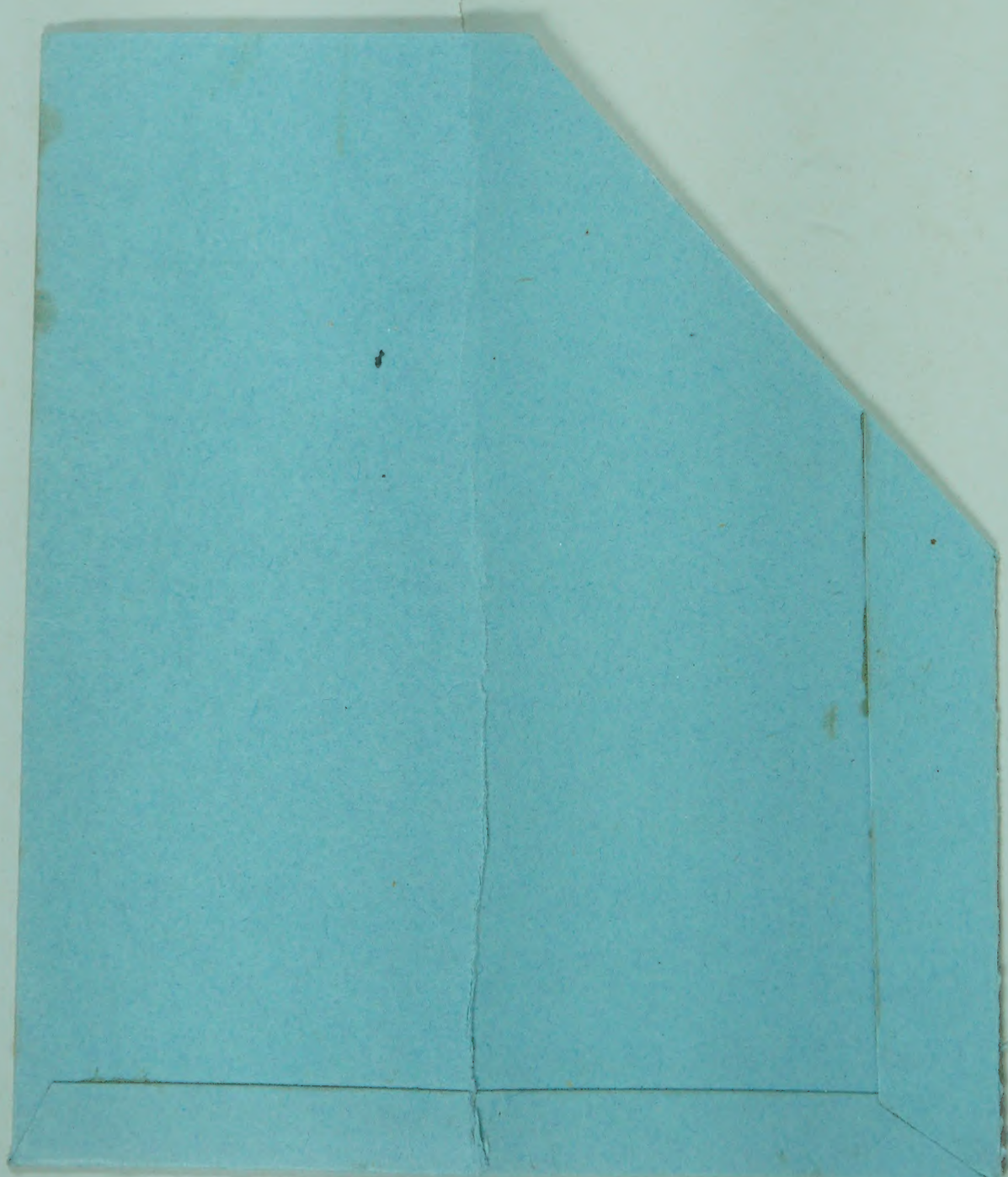

GROWING TOGETHER IN THE HEALING MINISTRY

New Strategies for Asian Christians 2000 A.D.

Report and Recommendations
of the CCA Consultation on
the Healing Ministry
Bangkok, November 13-17, 1989

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Foreword

Over the years CCA has been committed to an involvement in health and the healing Ministry. In 1957 it had the first meeting in Hong Kong and in 1967, a second meeting was held in Japan on this concern. Since then the CCA, through its activities, has been keenly involved in the issues of health. Unfortunately this has not been consistent and explicit. Historically, the Churches in Asia have been involved in health care first in and through institutions and, more recently, through community-orientated primary health care programs. Much has happened in Asia in the churches and the International agencies since the last CCA Consultation.

The Christian Medical Commission (CMC, present Unit II) of World Council of Churches has also organized a study program on health, healing & wholeness which sponsored 4 Asian subregional consultations (South Asia, South East Asia, NE Asia and Oceanic). These have produced reports and recommendations which should serve as background material for continued Asian review and commitment to the healing ministry of the Churches.

There has been a newer understanding of health, healing and wholeness as part of the mission of the church. Also there have been many well-run grassroots level programmes of people's education and organization and development. These new experiments and experiences have brought about a new

understanding of social change and justice. There is need for greater sharing and learning from this vast experience, much of it Asian. The Church needs to rediscover and redefine its mission in this area. New Strategies for involvement with and for people and making health a reality for people must be taken up.

This is the report of the consultation on "Growing Together in the Healing Ministries, New Strategies for Asian Christians: 2000 A.D." which was held on November 13-17, 1989 in Bangkok. This consultation was organized in collaboration with CMC/WCC.

We hope this will serve those who are engaged in the healing ministry in various places of Asia.

Finally we want to express our special thanks to Dr. Daleep S. Mukarji, General Secretary of Christian Medical Association of India (CMAI) for his work on this report.

KENICHI OTSU
SECRETARY FOR DEVELOPMENT & SERVICE

Report of the Consultation on the Healing Ministry

1. Background

Asian churches have traditionally been involved in health and medical work for which they have often been recognised by other communities and local governments. Much of this is a legacy of the missionary movement in this region though recently local churches have taken up many new and innovative measures for greater involvement in health and health care delivery. Some of the institutions and hospitals we have inherited have become an economic and administrative burden or irrelevant and elitist. In these countries there is much illhealth, disease, oppression and inadequate or inappropriate services. The weak, the poor, the marginalised, tribals, indigenous communities and women are often neglected. Asian churches need to be concerned about these wider issues of health and healing in a context of the wholeness of mission— to preach, teach and heal.

Both CCA and CMC/WCC have been involved in health issues in the Asian Region. CCA has facilitated some workshops, conferences and meetings in the past. In 1958, at Hongkong, one year after the formation of EACC a meeting was organised. This focussed on "Christian Medical Work in East Asia Today". In 1967 a second major meeting was sponsored in Japan. In 1973 the CCA Assembly appointed a full time health consultant. Later health became a function of the Development and Service Desk. Over the years 1979 to 1989 various workshops on health were supported. Yet the concern for this issue was not sustained.

CMC/WCC had commissioners from Asia who helped CMC in some way to be involved with the needs and concerns of this region. In 1976 CMC embarked on a study on "the connections between health, being human, the community and the kingdom of God." In this process 4 consultations took place in Asia/ Pacific region in New Delhi (August 1980), Bali (April/May 1981), Papua New Guinea (October 1981) and Kyoto (April 1987).

Within a few Asian countries there has been strong national ecumencial coordinating agencies in health and the healing ministries (Indonesia, Philippines, India, Japan and Bangladesh). There were few contacts between countries and a desire expressed by many to come together, learn from each other and plan for the future. These efforts were encourgaed by CMC/WCC and CCA and a meeting was called in October 1987 in Singapore to plan for greater CCA commitment in health concerns. The CCA establishment generally supported this process of increased involvement and an ad hoc Planning Committee met in Bangkok in November 1988 to give concrete shape to future directions and actions for CCA.

The November 1989 Consultation had been specifically called to facilitate this process and help CCA to rededicate and commit itself to assisting and serving the Asian Churches in this ministry of health, healing and wholeness. It was part of a larger concern to help build a more just, sustainable and healthy socieites in this region.

2. The Consultation

This meeting brought together over 40 people from 16 nations with various backgrounds, experiences and commitment. Yet all shared their concerns and worked together in a spirit of solidarity and urgency to see what could be done by CCA, the Asian churches and more specifically each participant to contribute to making health a reality for the people of Asia. A review of people's expectations at the start of the Consultaions brought out the follwing as vital issues:

a) To learn from each other and share experiences.
b) To have a greater understanding of the mission of health, healing and wholeness and then how to practice and promote it.
c) To strengthen, support and encourage greater Asian collabroations, exchange and cooperation in health concerns in the future.
e) To help develop policies and programmes for CCA, Asian churches and national ecumenical bodies in health issues with special reference to women, the poor and the marginalised.

Rev. M. Azariah, Moderator, Development and Service, CCA, at the opening programme reminded participants that Jesus called his disciples from being "no people" to become a

community and they were sent out to society with one mission having three tasks a) preach the good news (b) heal those who are sick (in body, mind and spirit and (c) to cast out demons. Today in all our nations the forces of evil, darkness, injustice and exploitation have great influence. He hoped that CCA would take up the challenge in the context of this 'oneness in mission' to see how healing and wholeness can become an integral part of the life and witness of Asian churches.

Dr. Kenichi Otsu shared the CCA desire to bring health back as a priority of CCA and wanted the consultation to suggest concrete, workable recommendations on how this could be taken up. Rev. Park Sang Jung, General Secretary, CCA requested the consultation to discuss and develop plans for the future. He appreciated this collaboration between CCA and WCC in and through the consultation and noted there were no ideological or theological differencess in CCA or CMC over an understanding of health, healing and wholeness. He expected the consultation to give clear and articulate recommendations to CCA on how it could continuously engage the Asian Churches in a ministry of healing in a sustained way.

Dr. Erlinda Senturias and Dr. Bert Supit in their separte key note addresses (*Refer KN 1 & 2*) gave the background and some future directions for the group to consider. We need to examine whom do we really serve and who benefits from our present involvement in health care. Dr. Senturias reminded delegates that involvement in such a mission could be risky but it required from us a desire to change structures, empower the poor and to truly understand why and how Jesus himself was involved in such a mission. Dr. Supit raised specific issues relevant to East Asia (*details in KN 1*).

(i) The role of the congregation in the healing ministry.
(ii) Health and social justice.
(iii) Hospitals and primary health care.
(iv) Financing of health care.
(v) Education and training for the healing ministry.
(vi) Biotechnology and genetic engineering.
(vii) The place of traditional medicine.

One of his expectations at this consultations was that "time will be given to look into the operational mechanism of all the christian health organisations in East Asia where a stronger networking could be established."

During the Consultation, the Bible studies, sub regional reports, group discussions and social time gave ample opportunity for intense dialogue, sharing and learning. Truly all experienced a 'growing together' as we heard of people's struggles, successes, failures and efforts in various parts of Asia. A young speaker from Burma, where recent troubles and strife had hurt so many, shared his personal pain and suffering. Yet he also shared the hope and vision of a future - of peace, harmony and justice. Participants from Laos and Sri Lanka shared their difficulties and the nature of their wounded communities. The delegate from Nepal reminded people of how just being christian would deny you basic human rights and possibly mean imprisonment.

In this process a community was built of people eager to see change and action. The group discussions on the specific topics gave a chance for them to contribute to the future of CMC, CCA, the churches and national christian ecumenical health organisations.

Some other issues that came up in the discussions need to be noted:

(i) Do we all have the same understanding of the mission of healing, health and wholeness?

(ii) Do church structures, departments and procedures fragment the one mission of the church - for wholeness and salvation?

(iii) How can there be greater sharing within Asia, between its 'rich' and'poor' countries?
Could there be something that both receive and give in a two way process of mission and partnership?

(iv) What is the place of evangelisation in the healing ministry ?

(v) How do we handle new health problems - drug addicts, refugees, AIDS, aging etc.

(vi) There is need for healing within and between nations in Asia because of our history of ethnic, social, military and colonial strife. How can we contribute to this? Specific situations here were between Japan and Korea (and other nations), within New Zealand and Australia, in India and Sri Lanka and elsewhere.

(vii) All countries faced a problem of shortage of committed human resources, funds and supplies. How does the church handle this?

(viii) The minority nature of the christian community in most Asian countries was noted. How do we work with Governments, other communites and agencies?

(ix) In the context of the forces of modernisation, urbanisation, militarism and western financial pressures how do we maintain our values, traditional customs, environment and healthy relationships?

(x) How do we educate, organize and encourage grassroot level participation by people in their basic democratic rights. How could people participate in decisions that effect their health and welfare?

3. Brief Reports of the Group Disucssions

(i) Church and the Healing Ministry.

The church represents a minority community but cannot use this as an excuse for no action. It must also realise that Christ is not the property of Christians. Our theology expects actions, involvement and mission in a world that God loves and is concerned about.

The healing minstry is about proclamation—the goodnews of health, wholeness and salvation. It helps to give purpose and meaning to life as it attempts to restore mankind and individuals to what God had intended. It makes available the resources of God for all people and is a foretaste of Shalom, harmony, peace and the renewal of all creation. It recognises that we live in a broken, wounded and unhealthy society. Families, peoples, nations and individuals are in need of healing. It is that dynamic ongoing process, that is made possible in a variety of ways to restore relationships and make whole that which is broken. It affirms Jesus Christ as the great healer and acknowledges a mandate given to all churches and every christian to preach, teach and heal.

The church is a gathering of the people of God, in community and fellowship. As an institution or structure it does not fit well in the Asian culture. The church as a movement of people, as a corporate body where people gather together, as local congregation and extended family is probably more Asian. In this context it has a prophetic and priestly role to serve the people of Asia.

With this background the healing minstry of the church can be enabled and expressed through its hospitals, health care

delivery systems and commitment to the weak and marginalised. The christian hospital is a palce where the church meets the world and it must be sensitive to the needs of the community. The healing team in our hospitals, private practice, government service etc. becomes the body of Christ and must play back this experience to the local congregations.

HEALING is the MISSION of the church. There is a commitment, understanding and acceptance required by churches and their leaders, CCA, NCCs and others of this basic assumption. CCA needs to promote this concept and prepare local congregations and health professionals for this wider understanding of mission and service of the churches.

(ii) Health and Social Justice.

Poverty, maldistribution of resources and oppressive structures have destroyed the inherent sense of community and family in Asian culture. Not only this — creation itself is being destroyed by our exploitation and misuse of natural resources. The Asian people have a special relationship with land, nature and environment. Our understanding of wholeness and wellbeing must include the healing of relationships with nature and creation.

Our societies are sick. The church needs to be an agent of change to promote the building up of a healthy and just society. This would require putting 'health' in the hands of people and empowering them to be responsible for all aspects of integrated and comprehensive development.

The CCA could strengthen existing networks for this task, exchange information, prepare leaders, share information, identify models of the local church's involvement in the healing ministry and develop a directory of resources. The preparation of people for such a mission of health and social justice is critical.

(iii) Education and Training in the Healing Ministry.

In the context of a wider understanding of health and the mission of the church in healing it is recognised that people are not specifically trained or prepared for this. This includes the traditional health professional courses (for doctors, nurses, allied health professionals etc) and the clergy who have a role to provide leadership in the church. Human resources development then becomes a priority if we are to make an impact in and through the healing ministry.

Innovative training has been attempted by some Asian Churches for village health workers, health assistants, community health guides, family care volunteers etc. These need to be encouraged and supported. Yet every christian needs to be sensitised to his/her role in the healing ministry.

A curriculum for health, healing and wholeness could be developed relevant to Asia. More importantly a strategy to educate and train key health workers and pastors may be developed by CCA, CMC and NCCs. This could include exchange visits, training of trainers, development of resource material, provision of scholarships and the support of existing and new training centres.

The place of traditional medicine and the socio-anthropologic perspectives of health, illhealth and health care in the Asian context must be kept in mind. Our traditions, customs, heritage and systems have their value. They need to be understood and incorporated in an Asian approach to the healing ministry and training of people.

Education should free people to think, analyse their situation and plan to do something about it. Therefore basic education itself may need to be widened to allow greater freedom, responsibility and action. The church should develop formal and non formal programmes for training in the healing ministry to prepare the whole health team. Within Asia this could be taken up at a subregional, national and local setting with flexibility in training methods but clarity in training content and objectives. It is important that a specific group of CCA be responsible to develop an appropriate strategy and work with churches, eccumenical coordinating agencies and NCCs.

(iv) New Emerging Issues in the Healing Ministry:

This group reviewed the Asian scene and attempted to identify priority issues emerging as health concerns. This was due to the demographic, commercial, industrial and social changes taking place in the nations of this region. These were as follows:

a) Ethical Issues
- — Euthanasia
- — Rational Drug use, production and marketing
- — Milk products/powders
- — Insecticides

— Biomedical technology
— Distribution of health care services.

b) Substance Abuse — Drugs, tobacco and alcohol

c) Mental Illness — of various types, including depression, broken relationships and stress.

d) Womens' Issues — Abortion, prostitution, Asian brides, teenage pregnancies, safe mother-hood, sex determination/ girl child, status and education of women, working mothers.

e) Aging and the care of the elderly

f) AIDS

g) Ecological crisis/ environmental health issues

h) Health problems of industralisation/ Urbanisation and militarism.

i) Family health issues - values, life styles relationships, death and dying, appropriate Sex Education.

Each subregion, church and NCC has to work out the priorities for follow up relevant to their situation and consider action plans. The church has a tradition of caring, compassion and a willingness to take up new social issues. We can be an example to others to develop suitable models of care and support. At the same time advocacy for policies and programmes may be needed within and between countries as many of the emerging problems have wider dimensions often beyond Asia.

(v) Strategies for cooperation and sharing in Health/Healing Ministry:

This was basically taken up by all and some of the suggestions have been taken up as plenary recommendations given below.

4. Recommendations.

A. To CMC/WCC.

1. Popularise Asian issues through CONTACT and other WCC publications.
2. Encourage South to South dialogue within Asia and beyond Asia.
3. Recognise and support churches, CCA, Asian and national health networks and innovative initiatives. Where possible delegate or decentralise activities to work with regional coordinating agencies and have close collaboration with CCA.

B. To CCA.

1. Develop a policy statement on health, healing and wholeness with a specific strategy to serve and assist Asian churches in this ministry.
2. Expand and strengthen networking of Asian churches, christians and health workers— hold follow up consulations on a more regular basis. CCA also may need to work at a subregional level to recognise the diversity of problems and the social context in which they have to be handled.
3. Make a directory to existing health, healing and wholeness networks. Where they exist at a national level, encourage and support them. Where they do not exist, provide advice on possible formation for such eccumenical coordinating agencies.
4. Share information on health, healing and wholeness through CCA News. Identify good models of the health, healing and wholeness practised.
5. Develop education and training material on health, healing and wholeness from Asian perspectives. Consider a strategy to prepare many people, especially local congregations, for this mission.
6. Conduct and impart training and education on health, healing and wholeness.
7. Facilitate exchange visits among Asian christians involved in health, healing and wholeness.
8. More specially within the structure and system of CCA make decisions to enable ongoing CCA priority involvement in health issues and the healing ministry.

This could be through creation of a working group or task force on health, healing and wholeness in CCA to oversee and moderate follow up action. The group should have representatives from subregions and WCC/CMC and have a link with a specific staff member/department or desk of CCA.

C. *To National Ecumenical Bodies/NCCs.*

1. Develop national and denominational statements on the healing ministry.
2. Support national ecumenical bodies in health. Facilitate the formation of new ones if needed.
3. Take up the new emerging issues identified at the consultation.
4. Publish health, healing and wholeness issues in existing publications.

D. *To local Churches/Denominations.*

1. Invest in training and preparing people for the healing ministry (at all levels, inter disciplinary, wholistic, inter-religious etc.)
2. Strengthen team work.
3. Link health with development and wholeness.
4. Reach training and educational institutions of the churches in promoting health, healing and wholeness.
5. Generate local resources for receiving exchange visitors.
6. Review present health and medical work in the context of a wider understanding of health, healing and wholeness and relevance to the needs and problems of the society. To make plans for the future of this ministry.

E. *To existing Christian Health Institutions, Hospitals and Programmes.*

1. Encourage exchange visits, sharing and continued networking.
2. Take up education and training for various cadres of health workers as a priority.
3. Contribute experience, plans and material to publication and education on health, healing and wholeness.
4. Develop a more wholistic approach in our health care services in keeping with our mission for healing and salvation.

5. Work with local congregations to strengthen their involvement in mission.
6. Recognise all members in the health team — the public, doctors, nurses, pastors, teachers, administrators, allied health professionals etc.
7. To help make health a movement of the people for a better quality of life (abundant life).

5. Conclusion.

There is a Korean Proverb which says "Body and Soil are one". This unified understanding of creation is common in traditional Asian Societies. Among the Maories, for example, it is believed that the individual who has lost ties to his/her tribal land is an individual divorced from spiritual sustenance. From the land comes food, water, trees and basic ingredients to support life. The Bible affirms that the "earth is the Lord's, and the fullness there off".

This traditional understanding of the unity of creation and its fullness has been violated/ destroyed by an orientation of dualism, colonialism, domination and greed of a few. This has resulted in impoverishment of people, dispossession of resources and creation of oppressive structures that hinder our growth into a whole new creation—a healthy community.

As one body with different parts, independent yet reflecting and complimenting each other, we can have true solidarity if we share with each other our resources and our lives, placing our talents at the service of others and of our Lord.

The wholeness of mission expects us to see the people as one, not subject to fragmentation. Promotive, preventive, curative and rehabilitative services must be taken into consideration as we work for the physical, mental, social and spiritual well being of all.

Our vision as people of God is to put health in the hands of the people. This involves restoration of the fullness of creation, working for the liberation of the poor, accompanying the struggle of the poor and becoming the wounded healers. The congregation as a community of the people of God is the channel to help bring this vision about.

We Asians have our own ways to maintain and promote our health; we need to rediscover our traditional ways. We are called to show compassion towards suffering. This requires involvement

in sacrifice, an identification with the one who is in need in pain and distress. It is to fulfill God's promise of fulness of life for every one.

At various levels (WCC, CMC, CCA, NCC, National and local churches) we can develop a cadre of people to create awareness and empower each other to participate in restoring the wholeness of creation.

Life style and body and soil are one— because this is our unique understanding. We become fragmented by becoming institutional. This has caused all the ill health and injustices that are present within us now.

We, as the Church, must confess that we have participated in stopping the growth of people — spiritually, socially, economically, physically and mentally. Working together, with God's help, we can make a difference. We can help people to help themselves. We can respond positively and effectively to our Lord's commandment to preach, teach and heal.

We recommend a strong endorsement by CCA to an ongoing visible and supportive involvement in the healing ministry essentially for the following reasons:

(i) There is a Biblical mandate to preach, teach and heal and the church recognises this involvement in health, healing and wholeness as an integral component of mission.

(ii) There is much brokenness in Asian societies where the church can play a significant role in healing, wholeness and the building of healthy and just communities.

(iii) Traditionally Asian churches have been involved in health and medical care. There is need for a revitalisation of this ministry in the changing context of our societies and understanding of mission.

(iv) New health and social problems are emerging in this region which need sensitive, urgent and compassionate response. The church has a specific role and potential in this situation.

We appeal to CCA structures and decision making bodies to make this concern a priority and develop explicit plans for a time bound commitment in health and the healing ministries. We suggest another review after a few years. New strategies of involvement with and for people to make health a reality for all people must be taken by CCA now.

For many this is truly a matter of life and death.

We appeal to Asian churches and christians to recognise the illhealth, injustice and brokenness in our societies and to revitalise our mission of healing and wholeness to play our part in building a new society — a new creation, the Kingdom of God. Jesus said, "I have come that they may have life — life in all its fullness". May His church take this as a challenge to continue His mission.

CHRISTIAN MEDICAL COMMISSION/ CHRISTIAN CONFERENCE OF ASIA (CMC/CCA)

CONSULTATION ON THE HEALING MINISTRY

1. *Dates* : 13th - 18th November 1989

2. *Venue* : YMCA Bangkok, Thailand

3. *Theme* : **Growing together in the healing ministry— New Strategies for Asian Christians 2000 AD.**

4. *Objectives* :
   i. To understand why the Churches should be involved in the ministry of health, healing and wholeness.
   ii. To examine how the Churches can grow together in this ministry.
   iii. To review the present involvement of the Asian Churches and CCA in health and social justice.
   iv. To plan new strategies for CCA to get more specifically involved in the healing ministry- giving policy, programme and action plan guidelines.

5. *Programme Summary*

13th November 1989 (Monday)

9.00 a.m. : Opening worship (*Appendix I*)

10.00 a.m. : Welcome and Greetings.

11.00 a.m. : Keynote address I.
"Review of Past CMC/CCA Involvement in health; Present Situation and Issues" by Dr. Bert Supit. (KN I)

2.30 p.m. : Keynote Address II
"Growing Together in the Healing Ministry—New Strategies for Asian Christians 2000 AD" by
Dr. Erlinda N. Senturias (KN II).

4.30 p.m. : Group Discussions.

8.00 p.m. : Community Building.

14th November 1989 (Tuesday)

9.00 a.m. : Worship and Bible Study I.

11.00 a.m. : Sub Regional Reports

to : a) North East Asia by Dr. Hiromi Kawahara (SRR 1)

4.00 p.m. b) South Asia by Dr. Daleep S. Mukarji (SRR 2)

c) New Zealand by Ms Koa Marshall (SRR3)

d) Australia by Rev. Ruth O' Sullivan (SRR 4)

e) South East Asia by Dr. Nemuel Fajutagana (Report not available)

4.30 p.m. : Sharing experiences.

8.00 p.m. : Sharing experiences.

15th November 1989 (Wednesday)

9.00 a.m. : Worship and Bible Study II

10.00 a.m. : Presentation by Rev. Park Sang Jung General Secretary, CCA.

11.00 a.m. : Group Discussions I

2.00 p.m. : Visit to Bangkok Christian Hospital and free time.

16th November 1989 (Thursday)

9.00 a.m. : Worship and Bible Study III

11.00 a.m. : Group Discussion II

2.30 p.m. : Group Discussions III

4.30 p.m. : Group Discussions IV

8.00 p.m. : Cultural Night.

17th November 1989 (Friday)

9.00 a.m. : Worship and Bible Study IV

11.00 a.m. : Plenary I

2.30 p.m. : Plenary II

4.30 p.m. : Plenary III Summing Up and Recommendations.

8.00 p.m. : Closing Worship (*Appendix II*).

6. *Bible Study Leaders:*

Bible Study I &II	:	Rev. A.C. Oommen (India) (*Brief Summary—Appendix III*).
Bible Study III & IV	:	Dr. Elizabeth Tapia (Philippines).

7. *Group Discussions* : 4 Groups (*Details Appendix IV*)

The 4 Group major topics, one for each group, were

(i) Church and the healing ministry
(ii) Health and social justice
(iii) Education and training in the healing ministry
(iv) New emerging issues in health and healing Ministeries : Beyond institutional health care and services.

8. *Participants* : *List in Appendix V*

This included leaders of CCA and CMC, staff of CCA and CMC plus others from Asia Pacific region. Key participants included:

Dr. S.M. Chowdhury (Bangladesh) President CCA

Rev. M. Azariah (India) Moderator, Development and Service, CCA.

Dr. Hiromi Kawahara (Japan) Commissioner, CMC/WCC

Dr. Bert Supit (Indonesia) Commissioner, CMC/WCC.

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I
REVIEW OF PAST CMC/CCA INVOLVMENT IN HEALTH PRESENT SITUATION & ISSUES

Introduction

It is a privilege and honour for me to deliver this first keynote address to this very important gathering of CMC/CCA related people that are concerned and are participating in the healing ministry of the Church.

I was asked by the planning committee to review in this consultation the past CMC/CCA involvement in health, and then to outline our present situation which at the same time will touch serval issues that are our common concern and interest.

I am aware that this gathering of christian health related people who come from all parts of East Asia and Oceania is the first gathering ever after more than twenty years ago when such a meeting was held in Japan sponsored by the East Asia Christian Conference (presently called CCA).

I suppose only a few of us who are present in this consulation do have some remembrance from the conference in Japan. I am aware and I am sure that much has happened in our churches and society during the last two decades. Many changes and progress have been made but eventually there maybe many setbacks and status quo being noticed as well.

I have to say initially also that in this paper I will not dwell in the past global involvement of the Christian Medical Commission of WCC as such but I will rather limit my deliberations on the Asian situation and try to reflect on issues that had been raised in the past two decades. Some of the concerns that I am going to mention in this paper are illustrations of past statements by many national and regional conferences as well as individual assessment of the health situation in Asia.

I am also aware of the problem of complexity and diversity of the East Asian and Oceania reality, and therefore any attempt to try for a convergence of concerns on health issues based on such a diversity of backgrounds will create a confusing and

maybe frustrating atmosphere in this conference. I am sure that each of us in this conference will later share her/his own experiences and assessment of their Churches involvement in health during the plenary and group discussion in the course of this week.

Finally, let me highlight one observation to illustrate our Asian continent's large but rich diversity in culture, tradition and religion. In this Asian reality, the Christian religion is only a small minority but in some parts of the continent it is a fast growing religion. (Korea, Indonesia)

As a minority religion among the other large world religions in East Asia, Christianity has been struggling for its own Asian identity making it distinct from the colonial powers that had come together to East Asia. Harvey Perkins identifies these struggles of identity around two issues namely values and power. Some of the Asian characteristics of poverty, hunger, malnutrition, etc., are felt as a commonality because of the struggle for development against the exploitation and domination of western economic power.

The reality of economic diversity in Asia itself can be illustrated also by making a distinction between the three Asian subregions. The Indian sub continent is being regarded economically as the poorest in relation to the Asean Subcontinent, much more to the North East subcontinent which comprises Japan, Korea, Hongkong and Taiwan. And therefore even in the East Asian setting one cannot escape by observing the struggle among people toward subregional identity in terms of values and economic power. We hardly ever speak about the Oceania subcontinent in this particular issue.

Review of the past.

In brief I would like to highlight several incidents in the historical journal of the fellowship of churches in East Asia and Oceania who are trying to witness to the ministry of healing.

In 1958, exactly 31 years ago after most of the Asian countries had become politically independent and the churches consequently become self governing from western missionary churches; Asian Churches and their medical institutions through their delegates consisting of ministers, medical doctors and nurses sponsored by the then East Asia Christian Conference (presently CCA) met for the very first time in Hongkong.

The 1958 Hongkong Conference was a culmination of East Asian Churches awareness of their common role in the development of health in Asian countries.

The Hongkong Conference has put consistent emphasis on the strategic witness of the individual Christian in medical work, whose field of service lay outside the church related institutions.

This individual approach and vision of the Hongkong Conference was illustrated in its findings that :

— there should be ways of strengthening the relations between Christian medical workers and the churches.
— concentrating on professional training of Christian Medical Workers.
— build up a cooperative relationship between christian medical workers in Asia.
— seek financial and personnel support for christian medical service in Asia.
— and the need for pioneering in new medical fields.

However after the Hongkong Conference took place rapid change in the socio-economical and political situation of nations and people in the world and in Asia in particular was observed. Secondly, during the post Hongkong Conference there has been the development of new theological insights instigated by the Tubingen Consultation on the healing ministry of the Churches which have come to be expressed in the concept of a Christian presence in development in Asia. Thirdly in the light of the changing social situation and the emergence of new theological understanding of the healing ministry, it was felt that a second conference of Asian Christian medical workers should be organized to discuss about the wider understanding of Christian presence and Christian participation in the healing ministry in Asia. Furthermore it was felt that some concrete commitments and provisions in terms of the training of Christian health leadership, the development of organizational structures and patterns of cooperation between national Christian health organizations were needed. To achieve these goals personnel and budget were taken up by the Second East Asia Christian Medical Workers Conference in 1967 at Gotemba, Japan, sponsored by EACC.

Indeed, the 1967 Christian Medical Workers Conference was an important milestone in the history of common vision and cooperation among churches and medical workers in East Asia.

Contrary to the 1958 Hongkong Conference, the Gotemba Conference of 1967 produced a wide range of recommendations touching such important issues like the study of the rapid change of socio-economic as well as political and cultural situation in Asia; the role of the congregation in the healing ministry as well as establishing of a permanent committee within the EACC structure to secure the continuation of cooperation and coordination of Churches and Christian medical work in East Asia.

An interim committee of 7 people was appointed and it was only after 5 years that in 1973 at the 5th CCA Assembly in Singapore a health consultant and a full time technical consultant were appointed.

At the time of the appointment of a fulltime staff to coordinate the health concern of CCA new developments in the theology and philosophy of churches involvement in socio economic development all over the world including the Asian Churches were already coming out. The seventies was characterized by the deep involvement of Churches and Christian action groups in the global and regional discussions of how Christians should be involved and participate in the struggle of the majority of people to eliminate poverty, hunger, disease and injustice. It was recognized generally that disease, malnutrition etc. are a result of injustice and oppression and God's mission in sending Jesus Christ into the world was primarily to release people from various kinds of bondage such as disease, poverty, exploitation, suffering, etc. If it was God's purpose that people should be released from these, it is only natural and imperative for Christians and Christian Churches to follow this teaching and get involved as agents of social, economic and political change.

Based on these theological reflections, CCA Health Concern orientation was focussed therefore primarily on its involvement in community health and development which was the seed of Primary Health Care that was later developed by WHO during the Alma Ata Conference in 1978.

This new approach to health and healing was taken up simultaneously by many churches and health related Christian organizations all over the world. Workshops, trainings of community health workers as well as promotive and preventive health programs were implemented wherever it was feasible.

It was only regrettable that CCA Health Concern fulltime staff member had to resign so early in 1977 leaving the position

open. Therefore CCA was unable to continue the much expected role of supporting and coordination towards its Asia Health constituencies.

Between 1981 and 1983 CCA Health Office was fortunate to be served by another fulltime consultant and there was for a while strong and motivated activities being felt from CCA by its Asian Health constituencies. Unfortunately CCA's role in the Health and Healing Ministry was again diminished after 1983.

In the meantime it was indeed very encourging that while activities at CCA level often fluctuates between high peaks and bottom low, other organizations have taken up responsibilities in carrying out the common vision and common effort in the various segments of the healing ministry of the church in East Asia. With respect I would like to mention in this paper the important and fruitful role of the following organizations :

1. Asia Health Institute from Japan which was very instrumental in carrying out training efforts for health professionals and community based health workers.
2. ACHAN, based in Hongkong and recently in Madras is secular Asian health action network and is very active in promoting and stimulating community health work in East Asia.
3. International Conference of Christian Physicians (ICCP) had taken up the responsibility of putting great emphasis to the ethical, moral and spiritual formation of the christian medical workers. (Now called ICMDA)
4. And of course we have the Christian Medical Commission of the WCC in Geneva which was very instrumental in promoting the three subregional study conferences on health, healing and wholeness which had taken place in New Delhi, India 1980, Bali, Indonesia 1981 and Kyoto, Japan 1987.

It is important to mention also that during the seventies and the eighties national coordinating agencies of christian health work were established in most of the countries in East Asia where they have taken the responsibilities to promote national strategies for Christian involvement in health services.

These national coordinating agencies were also instrumental in fostering the sharing of information, experiences and personnel among christian health organizations.

Out of the activities of these national coordinating agencies it is worth to mention that the North East Asia subregion countries have established a very active cooperative mechanism among themselves.

It is expected that in this consultation time will be given to look into the operational mechanism of all the christian health organization in East Asia where a stronger networking could be established.

Present Situation & Issues

Let me highlight some elements of our present situation in East Asia to illustrate the health issues that are facing us.

1. The Role of the congregation in the healing ministry

The most significant contribution that the Tubingen Consultation more than 30 years ago has made to the thinking on the healing ministry is the "Rediscovery of the Biblical truth that healing should be the concern and responsibility of the Church as a whole, the congregation in particular and not of its health or medically trained members alone".

Now the question must be put before us, after 30 years of the Tubingen report, what has been achieved by the churches, the congregation in particular to make the statement a reality or at least an operational strategy.

I must confess that I have found out many reports, statements as well as observations that churches especially congregations have not taken up seriously the basic biblical understanding of the healing ministry like it was described in the Tubingen Report. How does it happen and who is to blame for this failure? Why do churches and congregations generally fail to realize their responsibility and to show their concern for the sick of body and spirit? It could only mean that there is something basically lacking in the spiritual nature of the church and the congregation.

We have to ask more self searching and sweeping questions about the whole state of the Church and the Churches in East Asia in particular.

It is because Churches hierarchy and theologians are too occupied with structures, dogma and intellectual exercises on different theological interpretations of the ministry of our Lord Jesus. In so doing they have lost the grasp of defining strategy

and means, how to implement practically into programs the very important issues that they are arguing about.

The question must be asked also whether the health and medical professions who are very much concerned with this issue have not laboured triumphantly in isolation in trying to communicate the message from "Tubingen" to the "Secularized" Christian medical world.

As members of the Church we have to ask these questions in all humility. Are congregations and their pastors conscious and mindful of the definite purpose to which they have been called by God in the name of Jesus, to teach, to preach, to learn, to heal and to witness.

Are we losing sight of these most important tasks and goals, while burying them in the complex organizational structure of the Institutional Church which is probably unsuited to our basic Eastern culture and traditions.

Are Church or Christian controlled institutions only concerned with their interests and proprietory rights instead of being channels of witness and service.

On the surface these problems and questions may appear to be beyond the scope of our consultation here in Bangkok, but if "the Christian ministry of healing belongs really to the Church / Congregation as a whole" like it has been stated many times, then the Church as a whole should find an answer to these questions.

2. *Health and Social Justice*

In the last two decades social justice which is very much related with poverty, hunger, malnutrition, etc. was always on the agenda of Churches and christian action groups all over the world.

It was indeed obvious that the medical profession was for many years unware of the impact of social injustice on health. It was only the awareness in the seventies that most of the diseases that occurs in the world was the product of poverty; and that poverty in itself was the end product of oppression, exploitation and wars. The churches and christian health organisations started to take this issue seriously into their agenda for reflections. Although this awareness is happening, the same churches and Christian health organizations are trapped in the dilemma between the reality of their affluence and the much bigger reality of poverty and injustice.

We have to be honest that we are surely trapped between our neverending reflection of theology and social justice and the need for action to overcome social injustice.

To illustrate about this dilemma, let me raise Dr. Hari John's comments on this issue when she spoke to the Central Committee of the World Council of Churches in Moscow just recently.

She said : "The health status of the poor shows only a marginal improvement over the last four decades. Infant mortality and maternal mortality remain inhumanly high. Diseases of poverty like simple diarrhoea, childhood illness that are easily prevented and contained with simple and effective techniques like health education, have become killers.

"Millions of children die of malnutrition or become blind due to lack of vitamin A.

"All this in the midst of plenty, among centres of excellence that our mission hospitals and medical schools are, among the hundreds and thousands of professionals that we have trained in the past decades and with the vast amounts of "Christian" money that we have allocated for so-called health care.

"Something is obviously wrong. We have named the name of Christ but have not cared for the poor. We have tinkered with and perpetuated systems — institutions, professionals, high tech diagnostics, expensive drugs — that have not worked in the past and will not work in the future while deliberately shutting our eyes to the fact that only a structural change in our society brought about by empowering the powerless, can bring justice to the poor now, not beyond the grave.

"We have failed to demonstrate solidarity with the struggles of the poor and have been a conscious part of their oppressors.

"At the turn of the century, the poor of the world have a dream — a dream of a just, participatory, pluralistic and sustainable society, a society where people can live in "health" and dignity. With us, without us or even in spite of us, the poor are destined to achieve this.

"What is going to be the role of the Church?"

3. *The issue of Christian hospitals versus PHC.*

Christian hospitals in East Asia are a reality and are the inheritance of missionary work that have developed during the course of the 20th century into powerful medical institutions.

The medical professionals are always eager to develop and adopt more sophisticated technology almost irrespective of cost and without sufficient attention to priorities because they mostly fitted the interests of political decision makers.

The relative isolation of the hospitals from the broader health problems of the community has its roots in the historical development of health services which was due to a coincidence of many factors.

These are: the disease model of health care, the orientation of most physicians to the individual patient because of the training system, the technological imperative to use rapidly expanding medical knowledge and the tendency of all human organizations to expand and enlarge their own particular field or interest whether for profit, prestige or service.

What ever the reasons for this isolation of the hospitals, it makes no sense at all today.

On the other hand primary health care was a health strategy initiated during the seventies was accepted by governments, churches and society as a means to answer the demanding need to serve the people by promoting their self identity through participating and selfreliance.

After the Alma Ata proclamation in 1978 PHC become a global movement where governments have made it as the spearhead of national health systems to achieve health for all by the year 2000. However in the course of this development many PHC programs have suffered also setbacks due to many factors. It was indeed very sad that among many medical professionals they saw PHC as a kind of a threat to their medical profession and therefore were sceptical towards it. It is still obvious that many PHC programs are executed independently or seperately from existing health systems and financing of PHC has become a crucial issue for all parties concerned. Medical training institutions largely still maintain their traditional system of education and an impression of fragmentation of components within a national health system continues to exist.

There is now a strong feeling among many disciplines that we must not exagerate the apparent antithesis between hospitals and PHC, which is a false one.

As the insistance on universal coverage of population intensifies, and limitations of resources become increasingly obvious in almost all health care systems, it becomes clearer

that the services through hospitals and outside them has to be complementary, interdependent and therefore must be interrelated.

It is obviously true that hospitals represent the main concentration of health resources, professional skills and medical equipment. It is therefore obvious also that the hospital can give greater support in primary health care. This question should be central also for our Christian conscious.

4. *Facing the financing question together.*

It has been observed that it was possible to finance the operating costs of clinical services by charging fees, and as in most Christian hospitals services focused on these; in general this applies to these Christian medical institutions.

The same, more or less, also applies to the curative services offered in PHC, but as PHC programmes are stressing more on preventative and promotive health efforts these face the inhibiting factor to meet their costs when they offer immediate benefit.

For long it has been propagated that compassion for the poor and the helpless is to be offered without any expectation or reward, because such compassion is a reflection of God's nature.

And thus the quality of health care is not to be regulated by the ability of the patient to pay.

A study conducted by CMC on financing of PHC concludes that it is unlikely that PHC programme will ever be 100% selfsufficient, even where there is talk abour small community based initiatives. PHC programmes therefore will rely very much on government subsidies and donor agencies contribution now and in the future.

This can also be said for some rural and small town hospitals who are mostly serving the poor and middle class sector of the population.

Nevertheless the issue is still on the surface whether hospitals can take substantial responsibility in allocating part of its budget to support PHC programme. As preventive and promotive services within the traditional hospital context has been financed out of general income based on curative, and therefore income bearing service without many comments, it is obvious that the hospital should also become involved in financing preventive and promotive services in the community

as it accepts its calling to serve as a Healing Church caring for the world in compassion both as individuals as well as communities.

5. *Education and Training in the Healing Ministry.*

Education and training of Church officials and Christian health workers has been recognized as the most vital part to contribute to the church healing ministry in general, and to health care and primary or community health care in particular.

A common strategy of training and education of different levels of church personnel and health workers has always been a problem. There is still no concept of a synchronized orchestrated approach of curiculum or system that could train and educate the different levels of disciplines in the health hierarchy.

The performance and quality of health services through churches, christian health units and programmes will be very much dependent on the quality, dedication and sacrifices of church workers and christian health workers. I was once told by a non christian government official in Indonesia that in some way he could still make a distinction between a christian health service and a government health service. He was impressed by the quality of christian health services because of their compassion and dedication motivated by strong inner moral, ethical and spiritual values.

The question must now be raised whether it is still possible to preserve such a quality and attitude of Christian values facing todays realities in East Asia where materialism, consumerism and individualism are begining to dominate our daily life.

Today often the quality of health services is measured and valued according to physical development, intellectual knowledge and human skills only. There seems to be a gap between these qualities and the moral, ethical and spiritual qualities according to christian values.

Therefore, the question must be raised again how churches and christian health institutions could find the right concept to unite the two kinds of qualities making the christian health worker and its health programme still a unique christian identity for witnessing the signs of God's Kingdom in this world.

6. *Biotechnology - Genetic Engineering.*

A recent report to the WCC said that the revolution of biotechnology is now sweeping the world and is granting power

over the foundation of human life. New possibilities for controlling human reproductive choices are being conferred upon people. Humanity is now developing the tools for the design of life itself.

More disturbing are the clear indications from around the world that prenatal genetic analysis is being used for sex selection. In many countries, male children are prefered to female children. A recent study in Bombay, India, indicated that of 7000 abortions in one city hospital, all but one were female.

In 1986, concern over sex selection in South Korea became so severe that the government banned prenatal tests.

The issues concerning access to genetic information are made more intense by the ambitious and controversial plan to map every human gene.

Scientific expertise can indeed be used as a tool for intimidation and manipulation.

Because of the profound social and ethical implications of advances in genetic diagnostics and screening, the churches and christian health and medical workers have to take a stand towards these important issues.

7. Traditional Medicine.

Traditional healing practices and substances were discussed at all the regional meetings held by CMC in its study effort on HHW. Some of these centuries old practices and substances are now widely accepted or at least taken seriously.

In the Asian context where traditional medicine is a very rich resource, it was strongly felt to integrate traditional healing and modern medicine because they are complementary. But on the other hand it was also felt that there will be constraints in the use of both. For western medicine, one is its high cost, for traditional medicine a major constraint is the lack of sufficient research and development. The impoprtant thing is to enrich and preserve the good practices and reject the harmful ones, including religious rituals which go against christian beliefs and values.

The importance of traditional medicine lies first in the sheer number of people all over the world who turn to it for health care. It is usually cheaper, more accessible and more acceptable to people in other cultures than western medicine because it is part of what they believe in and can understand. WHO sees it as an invaluable and essential health care resource while recognizing its hazards as well.

Conclusion.

In reviewing the historical past of CCA involvement in health one can run into the danger of being subjective in its analysis.

There is also the danger of omitting very important incidents that have marked the history.

Therefore I have raised the organizational implications through people and structures within the historical process at the level of CCA, saying that there are times of optimism, and that there are times of setbacks and negligence, I must say sincerely that at this moment we have to pay our respect to the present staff of CCA who after so many years have taken up the health issue again onto the agenda of CCA by convening this very important 3rd Asian gathering of church and christian health workers.

In reviewing our present situation and the issues that are confronting us, I deliberately did not touch all the health issues that have been the concern of churches and christian health organizations in East Asia and Oceania.

To my mind what I have presented to you are the burning issues that should be assessed and discussed again to find common ground of mutual action.

I hope that Dr. Linda Senturias will pick up from where I have left, when she will present in our afternoon session the vision and new strategies to help Asian christians grow together in facing the challenges of implementing the healing ministry in East Asia and Oceania.

Thank you.

DR. B.A. SUPIT

II

GROWING TOGETHER IN THE HEALING MINISTRY NEW STRATEGIES FOR ASIAN CHRISTIANS 2000 AD.

My dear sisters and brothers in Christ.

I would like to congratulate you all for attending this meeting and on behalf of the Christian Medical Commission of the world Council of Churches extend our hand in deep gratitude to the leadership of the Christian Conference of Asia for organizing this consultation on the healing ministries.

This consultation is very timely because next year CCA will hold its general assembly in Manila. We hope that the recommendations coming from this consultation will have a distinct place in the agenda of the Christian Conference of Asia.

The healing ministry is definitely not new to the Christian Conference of Asia. Dr. Bert Supit has ably traced for us the historical background of CCA's involvement in making a critique of the medical mission as introduced in Asia by missionaries and in pushing for a community based approach to health programs. Various approaches to the health ministry have their unique contribution in the particular period. Therefore, it is always good to evaluate and find out how we have grown over the years in our understanding of the health ministry and in actually practicing it.

The organizing committee chose the theme "Growing Together in the Healing Ministries—New Strategies for Asian Christians in the year 2000". The committee was acutely aware that certain concerns have been voiced to the effect that some aspects of the healing ministry have been left out in the process of highlighting the strengths and the necessity of promoting primary health care. We hope that this consultation will be a forum for us to come together and look at our growth in the healing ministry bearing in mind the people we serve.

Whom do we serve ? Why do we serve ? And how do we serve ? There are three important questions as we discuss the five thematic issues.

1. Church and the healing ministry
2. Health and social justice
3. Education and training in the healing ministry.
4. New Emerging Issue in health — beyond health care services.

5. Strategies for cooperation and sharing in health/healing ministry.

Dr. Hari John, a member of the Executive Committee of the Christian Medical Commission and advocate for grassroots participation in health in Asia spoke about health, healing and wholeness during the Central Committee meeting in Moscow last July 1989. She made a very sharp critique of the prevailing health system which was borne out of her two decades of living in an impoverished rural community in Deenabandu, South India.

She talked about the "class basis" of ill health that has been well recognised in many of our workshops not only in Asia but in many other parts of the world. Just take note of the number of diseases related to poverty—diseases that could have been prevented if proper food, safe water, satisfactory housing and just wages are available to the majority of the poor. Then she talked about the "class basis" of solutions in which even the church who profess to care for the poor "tinker and perpetuate systems—institutions, professionals, high tech diagnostics, expensive drugs—that have not worked in the past and will not work in the future."

Those of us who are here to represent the church need to grapple with these problems at hand. The health situation has deteriorated in many countries and we have not been able to solve the problems. Perhaps we have been talking rather than acting, or perhaps we have not been working on the root causes of ill health in Asia but just doing "hodge podge" work of scratching the surface. In the Tagaytay Consultation (1989) sponsored by CCA we said the problems are structural. If structural changes are needed to empower the powerless and to bring about health, healing and wholeness, what strategies do we need to help bring this about. Perhaps some of us are already engaged in helping in the transformation process in our respective countries. We need to share this here and we hope that we can accept pluralities of ideas as part of the richness of our faith expressions.

I come from the Philippines and I know it is not easy to be part of this process. One of our community based health practitioners Dr. Bobby de la Paz, was brutally killed inside his clinic in Catbalogan, Samar in April 1982. More recently a doctor who has been treating human rights advocates and

particularly treated a human rights lawyer who was earlier shot by anti-communist vigilante groups was also killed himself.

In addition, we have reports that medical teams have been harrassed by the military in the course of their work in the rural areas to help community health workers perform medical care among their people. It takes a lot of courage to accompany the struggles of our people for a just society that will bring about health, peace and wholeness of creation.

We need to share strategies. What I discover to be helpful is to go back to our faith resource to analyse or to help raise the awareness of people in various situations. Learning from the healing ministry of Jesus is a key to organising community and empowering people. At one time in Jesus' ministry He needed to give a second touch on the blind man (Mark 8:22-26) to enable him to see clearly the people around him. I am sure that the same thing is true with our own experiences in working with the people. In my personal experience it took several touches before I saw the plight of my fellow Filipinos. And daily we need to be touched by the power of the Spirit to enable us to feel and be moved to action so that the fruits of the spirit may be a continuing part of us and so that we may be able to bear the difficulties of working for change.

We need to see the value of community. We cannot do it alone. Remember the people who brought the paralytic to Jesus by letting him down with his bed through the tiles of the roof. (Luke 5: 18-20) Yes indeed, we need each other. We need to build healing communities. The crowd of people can be a barrier if they are not organised. Our churches should enable the people to understand this so that we can be part of the solution rather than be part of the problem. Traditionally, we have this in our culture. In Indonesia this is called "gotong royong". In the Philippines this is called "bayaninan". This spirit of helping each other is strong in the oriental tradition or culture. I cannot mention everything because I am not well versed in our cultures but I am confident that the spirit of interconnectedness is part of the gift of creation that we need to harness it to bring about positive empowerment for all.

Jesus did not reject anyone in need who sought for his help. He ministered to all but especially to the marginalised. He did not just receive those who called on him but he sought out those who were sick as when he visited the pool of Bethsaida (John 5: 1-9). In this pool many would gather and wait for the

stirring of the pool as it was their traditional belief that the first one who steps on the stirred pool will be healed. He dared to change this traditional belief by challenging the paralytic that if he wants to get healed he does not have to wait for the stirring of the pool but that he should "rise up, take up his bed and walk." Perhaps he wanted him to see that there are many possibilities or ways to be healed but first he must have the desire to be healed and then act accordingly.

He saw that the priest had a role in healing as when he instructed the leper to go to the temple for cleansing by a priest. He imparted the power to heal among his disciples. He did not claim monopoly in healing. He inspired those whom he healed by setting them free.

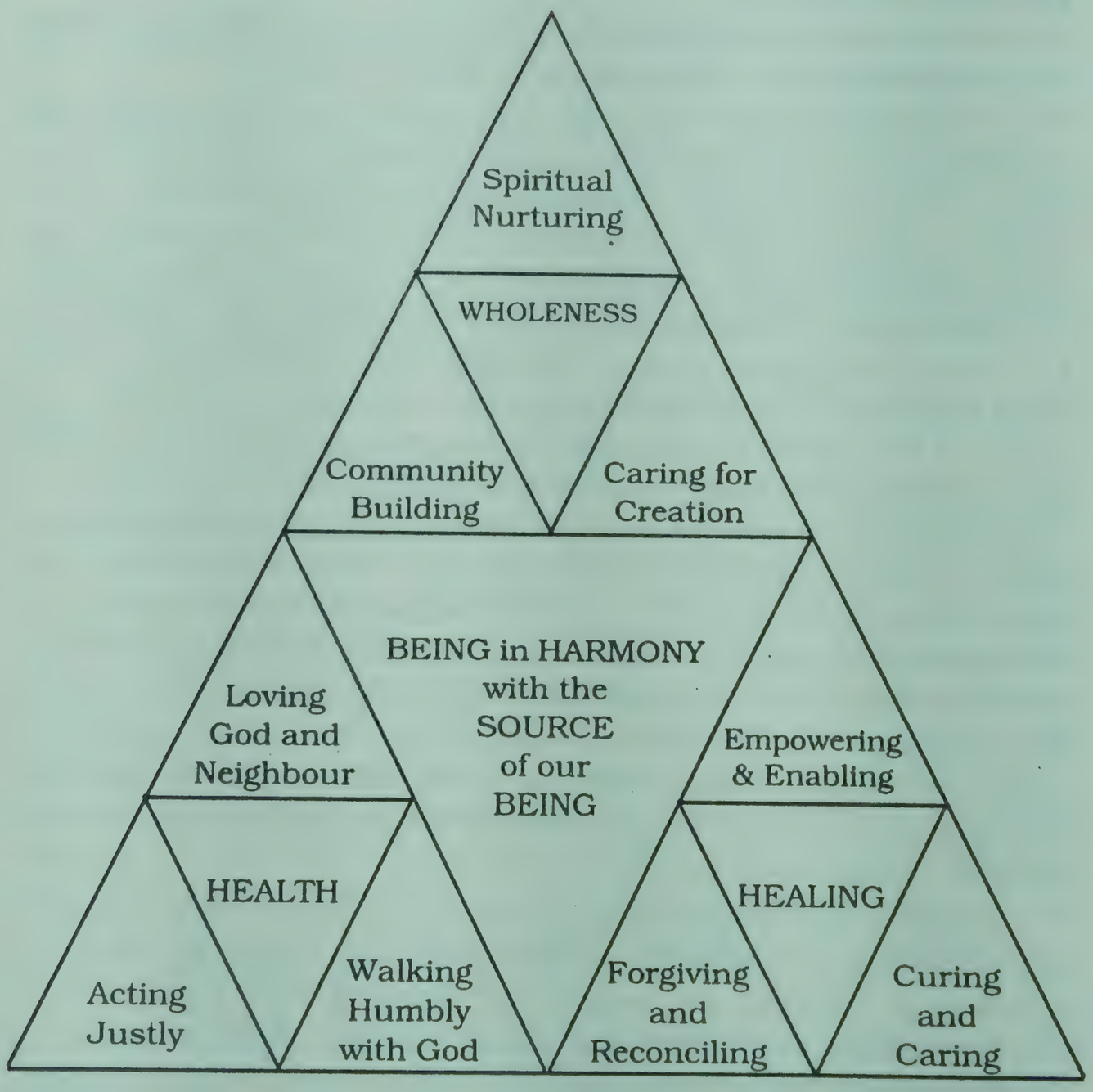
"Woman you are freed from your infirmities," he said to the bentover woman of 18 years (Luke 13: 10-13).

"Daughter, your faith has made you whole," he said to the trembling hemorrhagic woman who dared to touch the hem of his garment (Luke 8: 43-48). We could go on and on to cite Jesus ministry of healing. But he did not only heal he also proclaimed the good news taught in and out of the synagogue and withdrew in quiet places to meditate and pray. He grew in grace and in the favour of God and the people. He understood the presence of the Holy Spirit in him meant that he was anointed to preach good news to the poor, to heal the broken hearted, to set free the oppressed and to proclaim the acceptable year of the Lord. He organised a core group of people who will help him. He attracted great crowds of people in his ministry. He did not turn them away. He organised their resources so that they could be shared. He made sure that the children and women have a place in his ministry. He underwent mockery, difficulties, all sorts of risks in his ministry. He experienced death and the resurrection. He imparted the gift of the Holy Spirit that brings peace, sustains life, sets free, reconciles and transforms people and movements and the whole of creation.

Those of us trained professionally in the healing ministry as well as the people in the congregation are challenged to grow together in serving the people, in weaving our dreams for a healthy society and in helping transform our broken world. The challenge is for us to work hard these five days to help strategise on how to communicate health, healing and wholeness to CCA constituencies for the next 10 years and to present our strategies

as a clear agenda for the Christian Conference of Asia to consider. May the Holy Spirit guide us in our deliberations.

DR. ERLINDA N SENTURIAS.



1.
NORTH-EAST ASIA

HEALTH SITUATION AND CHURCH INVOLVEMENT

Citizens of China, Hong Kong, Korea and Japan, which partly comprise North-East Asia, share many common things in their histories, culture and in their contemporary situations. They belong to the Mongol race, and have been generally part of ancient Chinese civilizations and culture.

In their recent contemporary histories, they had been affected by Japanese militarism before and during World War II or by Western colonialism. Feudalism in the countryside, which has largely been the cause of poverty and civil unrest, has been officially and practically eradicated, only after the trauma of civil wars as in the case of People's Republic of China and Taiwan or Korea, or only after military defeat and unconditional surrender of a feudal-capitalistic military government as in the case of Japan. While the People's Republic of China and Democratic Republic of Korea are separated ideologically from Taiwan, South Korea, Hong Kong and Japan, all these countries have undergone land reform in different ways (capitalistic or collectivistic approaches), and have committed themselves to rapid industrialization programs since the end of World War II. Politically, while others profess to be in the capitalist or socialist camp, one common thing that has characterized these countries is the presence of different forms of one-party rule or one-party-dominated governments for over a long period of time. I wish to touch on these effects of the rapid industrialization of these countries, and the lack of genuine grassroots participatory democracy on the social and health situation, and the challenges for church involvement in North-East Asia. In addition, I also wish to establish a linkage of the North-East Asian situation with that of the whole of Asia and the other parts of the world. The challenges for church involvement increasingly become important as North-East Asia is being seen as a focal point of rapid economic development in the world today, with its vast natural resources (especially China). The prospects of investment, business cooperation as well as competition, among the different countries of North-East Asia could influence the general material and spiritual culture of these societies, the traffic of people

within the region (migrant workers, tourism, etc.), as well as the exchange of ideas. Necessarily, the rapid economic developments into the next century forecast for the region would surely affect the living standards as well as their health situations.

I. The social-health situation

A. The eradication of feudalism, accompanied by industrialization has benefited the people of these countries in North-East Asia. This has raised living standards, improved the supply of safe and sufficient drinking water, increased the production of food and introduced a medical health care delivery system. New technology, especially in the field of biotechnology, electronics and biochemistry have improved detection and monitoring of disease and scientific knowledge has improved and developed new cures.

B. On the other hand, industrialization has introduced new problems. Industrialization has always been accompanied by concentration of people — urbanization. While urbanization has advantages, such as quicker access to service and needed supplies, it presents both material and cultural problems. Housing in urban areas becomes more difficult, as land prices and apartment rentals increase beyond imagination. The problems of the homeless people and the urban poor are also witnessed in North East Asia. It is also quite an irony that, in general, middle-class urban-based people, cramped in highrise apartment buildings, get to know their community members less than those belonging to rural-based villages whose houses are more dispersed. Urban centers have always witnessed the highest causalty rates in terms of accidents (vehicle, fires, natural disasters especially earthquakes). Epidemics are more likely to occur in urban population centers.

C. Industrialization is related to machine-based production, which utilizes energy (coal, oil, electricity, nuclear energy), raw materials and labour, to produce finished goods for direct consumption or new machines such as cars, refrigerators, etc. Industrialization thus presents issues of raw material utilization and the environment. For net importers of raw materials such as Japan, these present many issues connected with the depletion of the natural resources of Third World countries, including rights of laborers and communities in host countries, including ethical questions regarding dealings with oppressive governments. Surely, the business activity of corporations overseas which

help deplete the Amazon forests of South America and the remaining virgin forests of Indonesia, Malaysia, Phillippines and that of mainland Asia would affect the global health situation, as these forests not only supply timber for housing, but also oxygen, and help control the rapid carbon dioxide emmissions from industry (as well as from human beings and animals). If the "lungs of the earth", as these forests are called, fail to function, there will be terrible consequences.

D. In the process of industrial production, unused waste products are expelled into the environment in the form of smoke, or dumped into rivers, lakes or oceans. The ozone layer, which forms a protective layer over the atmosphere, is slowly being depleted by some chemicals such as CFSs which slowly escape into the atmosphere. In North-East Asia, nuclear energy is being seen by Governments as an increasing source of power for industry despite the problem of radiation leaks associated with accidents, or during transport of nuclear wastes and their final storage considering that nuclear wastes have very long half-lives. This is a serious, continuing health and scientific challenge for mankind. Japan has a very high concentration of nuclear power plants, considering its limited land area. The Chernobyl accident, and previous to that, Hiroshima and Nagasaki, have shown that modern medicine is helpless in the face of massive nuclear radiation accident or warfare. Japan has also been notorious for a number of pollution-related diseases such as the Minamata disease associated with mercury poisoning, and Itai-Tai disease associated with long-term drinking of cadmium-polluted water, or even overuse of therapeutic drugs such as an anti-malarial drug which has caused SMON, subacute myelo-optic neuropathy which causes blindness. Surely, the so-called newly-industrializing countries of North-East Asia, in the rush for rapid GNP growth, are facing similar problems.

There has been debate on the problems of energy consumption-related environmental hazards. The burning of fossil fuels (oil) has been held responsible for the gradual rise of the global temperature, increased emissions of carbon dioxide into the atmosphere, and the so-called "green-house effect". On the other hand, while nuclear energy poses no problem with regards to carbon dioxide emissions, the dangers of radiation are immense.

We also have the phenomenon of "acid rain", another side-effect of industrialization. Indeed, global climates, the biosphere

and mankind itself is being threatened by the technological advances which mankind has created at a very rapid pace — over a period of 300 years since the start of the industrial revolutions.

E. Bio-technology, which North-East Asia, especially Japan takes a leading role in research and commercial development, presents both favourable prospects as well as bio-hazards. Unfavourable mutants, in the form of micro-organisms, if accidentally released into the environment, can present dangerous problems. While there seems to be a trend toward demilitarization in some parts of the world, militarism in some sectors of society can find a dangerous tool in biotechnology in the field of biological warfare. Ethical problems and religious questions also arise when bio-techniques enter the field of human reproduction.

F. The stresses of industrial societies of North-East Asia are taking its toll on mental health. Problems such as irritability, insomnia, nervousness and mental disorders, chronic alcoholism, drug abuse, suicides, and various crimes are all products of this stress-filled society. Alcoholism is one example of such problems. The national consumption of alcoholic beverages increases with the elevation of national incomes which results from industrialization. According to the statistics in Japan, 90% of the male and 45% of the female adults are more or less drinkers, and 2 million of them are presumed to be alcohol-dependent. We must take early steps to pre-empt (prevent) the social causes which contribute to chronic drug abuse which is now threatening the moral fabric of the United States, the world's leading power.

G. The irony of the increasing benefits of modern technology, in the field of elctronics and biotechnology for example, is the soaring medical costs. As more machines are used, and more expensive diagnostic tests are conducted, economic effort to sustain these medical support systems may become too expensive and may tax society too much as to affect their material, spiritual and cultural quality of life. One issue which we have to face is the issue of ageing societies, as well as the issue of prolonging physical life of comatose patients.

H. Changing cultural regimes brought about by industrialization, urbanization, and nuclearization of the family has brought about both positive and negative development. Women's liberation, shared parenthood and equality between the sexes are positive developments which are slowly making its

way in Confucian North-East Asian countries. On the other hand, while the nuclearization of the family has also partially contributed to women's liberation —it has brought about another problem of ageing parents and grandparents who are sent to Old Peoples' Homes to live lonely lives. While there are biological factors which lead to ageing peoples' diseases such as senile dementia, environmental factors also play an important role. Surely, these are also health challenges for us.

I. Organ Transportation technology, as well as in-vitro fertilization and embryo transplantation, while promissing relief for diseased individuals, or for people with reproductive problems, present some ethical questions. Organ transplants would require discussions between donor and recipients or their representatives. In Japan, this has become a very financial transaction, usually between Japanese patients and commercial agents which scout for "suppliers", usually convicts in the Philippines who "sell" their kidneys.

How do we confront these challenges, as church and health workers?

II. A Christian, perspective towards health and church involvement; some recommendations

How do we confront these problems of society and health, which have been brought about by the rapid rate of industrialization of societies in North-East Asia? The industrial revolution has been fuelled both by economic instinct and scientific advancement. While there has been material progress brought about by these technological revolutions, problems have been created which attack both the material and spiritual integrity of people, especially that of the working class, and the environmental quality of life —which threaten biological and human life itself.

Summing-up, we have the problems of the urban poor and the homeless, problems of prostitution, problems of migrant workers from poorer localities and from other Asian countries, the problem of economic refugees, problems of pollution within, and export of pollution outside the region. We have problems threatening the integrity of the family, problems of ageing societies. We have problems of business practices of companies towards their workers, and towards other countries, especially the Third World.

We need not just a country view, not just a North-East Asian view, but a global view in confronting these challenges. The economies of these countries (of North-East Asia) are largely tied up with the global economy. Intense competition in the international market has led to these rapid changes in lifestyles, both positive and negative, these mass movements of capital and people between countries, the large importation or movement of raw materials from one poor locallity or country to the industrial, manufacturing centers of North-East Asia. It is the rapid-growth societies of modern-day capitalism in the world which have tied the immediate future of the countries of North-East Asia to the intense, stress-oriented industrial lifestyles in these countries, and which are bringing out new health problems, while solving old ones.

It is difficult to simply make a critique of the overly materialistic challenges of capitalism, without making the necessary programs to attack the symptoms of the predominance of profit in modern-day society. Yet we need a global vision of an alternative —a Christian alternative, global in character, which would respect individualism and market mechanisms, with the corresponding social regulatory mechanisms and environmental considerations. The experiences of bureaucratic and over-centralized socialism has shown that too much regulation and control of human activity, including economic production, can impair the production process and human creativity itself. At the same time, the problems of modern-day capitalism also show that over-emphasis on the struggle for profit —for capital — brings about waste in the process of over production, waste and destruction of the environment in the rapid race to out manoeuvre competition in the world market; too much concern for profit does not make the capitalist think twice or thrice about checking the safety of products, or about his responsibility to his workers, to society or to the environment which has been the source of his wealth. This "dog-eat-dog" or "elbow society" of capitalism has also led to the "refinement" of sex industries, which also include pornography, child prostitution, sado-masochist clubs and call-girl services. Where else could we find "Sodom and Gomorra" but in modern-day capitalism where it is openly exhibited without shame.

Nature, God's creation, through ecology, teaches us that both competition and regulation are necessary if the proper balance is to be achieved. The introduction of democratic

regulatory and environmental checking mechanisms would suggest that the global economy must be oriented towards slow rate of material-growth, especially for the advanced industrialized countries, with human activity focusing itself gradually on non-economic forms of activity once the problems of starvation, clothing and shelter are met especially in the Third World, and these include health needs.

We have yet to define more clearly this vision of society for humanity as we enter the 21st century, and to reach a consensus among us and to work with our people in realizing our vision in the coming decades beyond the 21st century.

What concrete programs should we carry forward? In our respective countries, particularly in North-East Asia, which have relatively high-growth economies, health care has almost been taken over by the government. During the late 19th and early 20th century, especially in Japan, the Church played a significantly important and major role in the delivery of health care of the people. How do we confront this changed situation? How do we confront the health and health-related social problems outlined earlier?

A more pragmatic problem which may face Christian health workers, especially Christian hospitals, is the problem of surviving financially in a financially competitive atmosphere where both private (non-Church) and government hospitals compete with our Christian medical institutions. There are problems of supporting staffs and their families of these institutions in this highly financially competitive societies with their high cost of living, especially in the urban areas. In addition, Christian health workers and Christian hospitals are obliged to perform their duty to carry out clinical pastoral work and social action which is generally non-profit. How could Christian medical institutions survive financially in this competitive atmosphere, while carrying out its missionary medical and pastoral work.

I have summarized some recommendations based on the CMC Regional Consultation on Christian Perspectives on Health, Healing and Wholeness held in Kyoto, Japan in April 1987 and further elaborated on them after the group discussion we had yesterday.

1. Strengthen our programs in the rural areas of our countries, where governments tend to neglect needs and emphasise more health programs in the urban areas. Continue

to develop primary health care systems in the rural areas where the need is most urgent. For the poor sectors, carry out medical work among them by requesting government to support the primary health care programs of NGO's and the church, particularly in the rural areas. In addition, major Christian hospitals can re-route their funds to primary health care programs rather than expanding the number of beds or purchasing expensive equipment.

2. Churches can strengthen coordination among their medical institutions, especially in the acquisition of medical supplies, establishing referral systems between hospitals, establish electronic information exchange systems to facilitate transfer of medical data and to maximize use of sophisticated equipment which other church medical institutions have. Medical training programmes should be supported by the church, emphasizing programs which train doctors and nurses and other health workers who are willing to return to the rural areas.

3. Strengthen health education programs for parents, schoolchildren and teachers, so they can be involved in community health.

4. Strengthen counselling programmes for teenagers and parents to help them confront problems of teenage pregnancies; strengthen ethic-oriented sex education programs. Provide support and counselling to people and families with unwanted pregnancies, and to help improve communication between children and parents, and for those children who lack parental care (both parents working or single parent families). This can also prevent problems of child prostitution, street children or run-away children.

5. Church programs should not only attack health as an end in itself but should connect this with its alternative global vision of a more human society which shares and cares more. Thus, the necessity for "wholistic health" should also be seen as a process of functioning in harmony with the environment, with such virtues as faith, hope, charity, kindness, generosity, gentleness, self-control, dignity, fidelity, compassion, joy, peace and love.

This accent on Church social action suggests a role of the Church to act as a catalyst for social change, in unison with the people. While the separation of church and state is a cardinal principle of modern society, having learned from the Medieval ages when theocracies governed, Church involvement in social

action is not concerned with governing but in being a mirror of the problems and aspirations of the people. Church members themselves have to be educated about the problems in their communities and societies, and how they can bring about peaceful transformation of their environment. This suggests that more democratic and active participation of church members in public and community affairs is necessary. The participation of church members in legitimate citizens' movements concerning human rights, environmental protection, against the arms race and nuclear weapons, concern for the Third World, etc... should be encouraged.

6. Specifically, more in the field of health concerns:

6.1 To strengthen counselling for church members in North-East Asia, reportedly having many psychiatric problems compared to other developed regions, and to attend to the spiritual needs of the terminally ill.

6.2 Pay attention to the welfare and economic and physical as well as spiritual well-being of Christian health workers, and their daily struggles; pastoral care for them (especially among doctors where drug abuse and alcohol abuse is quite high);

6.3 Prevent the dumping of unwanted, banned, or restricted products in developping countries.

6.4 Facilitate exchange of information and experience in the area of industrial health care.

6.5 In view of the limitations of modern medicine, try to integrate the effective components of traditional medicine with that of Western medicine. To encourage scientific investigation and practical application of herbal medicine, so as to reduce the rising costs of medical care, whenever possible.

6.6 Strengthen primary health care training and education programs such as Asian Health Institute; strengthen overseas programs to assist primary health care efforts of NGOs in other Asian countries, especially that of the Third World such as Japan Overseas Christian Medical Cooperative Service (JOCS). While demanding independence from government control, request government support for NGO and church primary health care support programs in the Third World, as part of responsibility of the rapid industrializing countries of North-East Asia to their neighbors who are less economically developed.

6.7 While encouraging continuing government support for health care programs in the countries of North-East Asia, recommend that government support and guidance be more flexible so as to permit more self-reliance on the part of citizens in the field of health care. Emphasis on community health education can help a lot towards lessening dependence on centralized hospital-based health care which drives up the cost of medical expenditures.

6.8 Establish wholistic health care centres, and study the feasibility and viability of replication in other communities, such as that run by health professionals at Asia Center for Theological Study (ACTS) in Seoul, Korea.

6.9 Establish health care programs for migrant workers, especially from Asian countries; demand that governments support these programs since migrant workers also contribute to the economy (especially those in the construction and manufacturing sector). Special health care programs and counselling service as well as emergency assistance programs be developed for Asian migrant workers in the entertainment industries who are most often subjected to sexual, physical, psychological and economic abuse by unscrupulous employers (Japanese, or other similar situations in Taiwan, Hong Kong, South Korea).

DR. H. KAWAHARA

2.
SOUTH ASIA

CHURCH AND THE HEALING MISSION

A. Some Problems:

This part of Asia covers Bhutan, Bangladesh, Pakistan, Sri Lanka, Maldives, Nepal & India.

1. Very Large Population
   South Asia has a population of about 1100 million people in a very small land mass. This population is growing fast.

2. Socio-cultural, Economic and Political Situation
   These are ancient civilisations and all the four major religions can be found. Most of the people live in the rural areas and the economy is still very agricultural. There are castes, tribal and very real ethnic/racial and linguistic problems in their countries. Thus the political situation is very tense within and between countries. (Summary data available separately)

Over 50% people are below the poverty line with disparities between the rich and the poor being very marked. Health status is low and health service often inadequate and inappropriate. The usual problems of malnutrition, unsafe drinking water, communicable disease, poor hygiene and inaccessible health services with little or no health education contributes to the morbidity and mortality figures. Women are vey vulnerable, treated as second class citizens and left out of development.

3. The Christian Community
   This is very small and almost insignificant (2.7% of population in India, 1-2% of Pakistan, 0.03% of Bangladesh, 0.4% of Nepal and 1% of Sri Lanka). The climate for Christians is often hostile and they suffer persecution in some countries. Communal strife complicates the picture. Christians have a minority complex - feeling insecure, do not speak out and are generally isolated in small pockets. They have a ghetto mentality. The Church is weak, funds insufficient, leadership poor and health professionals inadequate.

4. Heritage of the Missionary Era

Today this region has many hospitals and clinics established essentially in the last 100 years by the missionaries. These Mission Hospitals have become wellknown for their service-with commitment, compassion and loving care.

Often the public prefer these centres. Missionaries and their funds are decreasing either because of policies of local government or churches or in the sending countries. The health institutions now have become burdens for the new and weak churches.

Thus hospitals are closing (almost 50%). They are outdated, having old building, equipment and personnel. Many which survive have become institutionalised, commercialised and seccularised as they seek to manage in a changing environment and specialise in different aspects of medical care. The survival of the hospitals have become central to many both in the staff and in the church. Relationships between the church hospital and the local congregation have not always been healthy.

5. The Church, the local congregation and the healing ministry.

There is very poor understanding, acceptance and involvement of the healing ministry in the mission of the church. For doctors the healing ministry is concerned with medical care, curing and the development of hospitals. For the Church establishment it is the survival of the hospital for the status, jobs and funds that this provides. For some christians the healing ministry is only faith healing, miraculous cure and is often done by traveling evangelists. For many this is only service - should reach the people especially the poor and is not seen as mission where the gospel is proclaimed. For the staff of the hospitals it is a job not a vocation.

6. Some Conflicts or Misunderstandings

a) Hospitals vs Primary Health Care. Could there be complementary and organised together? Some felt it was only one at the expense of the other for the Church.

b) The Church and its health and medical work have a dilemma and a serious problem of conflicting objectives. They are asked to serve the poor, to reach out to the weaker sections and help them help themselves. At the same time they are asked to be financially viable and often contribute to the activities of the church.

c) Curing vs Healing. For many the diference between curing and healing is unclear. Doctors feel threatened by new concepts of the healing ministry (almost as they did for PHC) and sometimes the church leaders feel these new perspectives on healing, wholeness and mission is entering their areas.

d) Primary Health Care (PHC) - what is this, how is it practiced and sustained are areas of misunderstanding. Often PHC is taken up because it is the latest fashion, funds are available and it can help the hospital and give new prestige. Others are questioning if the Church should be involved in the provision of PHC services or help educate, mobilise and organise the people to get and demand a more equitable and appropriate health service from Government.

B. Brief Country Reports (Presented Separately)

a) Bangladesh
b) Nepal
c) India
d) Pakistan
e) Sri Lanka

C. Summary Issues for the Consultation

1. MISSION: A need to redefine the mission of the Church with the healing ministry as an integral componant. This is to be understood and internalised by the Church and local congregations to be empowered with this vision and mission.

2. MANPOWER: The mission of the Church requires people especially trained and motivated to give expression to this commitment of the church. In healing it requires

the health team (including the chaplain) and thus a priority is to train allied health professionals, nurses, doctors (even upto appropriate post graduate levels) for this mission. There is also a need to emphasise and support grassroot level education and training of people in and from the community in the promotion and the maintenance of health.

3. MANAGEMENT

This concerns the organisation, control and running of the Church health and medical work. It requires improved systems, more accountability, improved relationships and the nurture and development of staff.

4. MINISTRY/SERVICE

The Church must examine the nature, extent and relevance of its service in the healing ministry. Whom do we serve, how and do we really contribute to making health a reality for the people.

5. NETWORKING

Within our nations and beyond we need to examine the possibilities of linkages, sharing and learning from each other. Between churches, between nations and between faiths we need to seek networks and activities that sustain fellowship between Asian Christians in the healing ministry.

6. PRIORITIES

For the Church there is need to set priorities within the overall mission of health, healing and wholeness. This needs to be related to the needs of the people and to be developed in a participatory process of decision making. It is better to do a few things well than many things badly. Priorities mean choices - positive commitment to what we can, must and will do at the expense of others things.

7. RELATIONSHIPS

The Asian Churches are coming to realise the necessity of new relationships. While links with old mission bodies in the West are becoming weak and loose we are searching for new bonds of fellowship and solidarity.

This is seen in uniting churches, the CCA, expression and the relationships between South and South nations. This requires new, dynamic and ongoing partnerships with the North, the donors and the older Churches.

8. Funding

No discussion on the healing ministry can avoid concerns for resources - finances and otherwise. How these are made available, who benefits and what it means to relationships between donors and recepients needs to be considered. How can we also raise local resources within local churches and the Asian nations.

9. Educations of the Public

Health needs to be a movement that empowers and liberates the people to their potential not only for their health and welfare but their full participation in the decisions that effect their future. We recognise that health and development are issues of justice and the need to build healthy communities. The Church then must be involved in education, awareness building and organisation that contributes to community building and social change.

10. New Emerging Issues in Health

The major problems are still malnutrition, poverty and communicable diseases. Yet new issues in a broken and wounded world need the concern of the healing ministry - broken homes and families, drug and alcohol abuse, womens health, care of the handicapped, rational drug therapy etc.

D. Hopes and Expectations

South Asia Churches and representatives come to this meeting with hopes and expectations.

1. We seek linkages and sharing. We pray for a mechanism or modality for coming together - to learn and grow as Christians. We request CCA to give leadership.

2. We want a revitalisation of the church - the local congregation. We expect a greater involvement and commitment to the healing ministry.

3. Training of the Health Team - preparing people and leaders for the healing ministry. They are to be agents of change and to be builders of the Kingdom of God.

4. Good follow up of the Consultation. We hope there will be a personal, Church and CCA commitment to follow up on the burning desire for fellowship, partnership and solidarity for Asian Christians in the healing mininstry.

DR. DALEEP MUKARJI

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SOUTH ASIA

Development Indicators

Country	Under 5 mortality rate		Infant Mortality rate (under I)		Total Population (millions)	Annual No. of births/infant and child deaths (0-40) (thousands)	GNP per capital (US $)	Life Expectancy at birth (years)	% adults literate male/ female	% of age group enrolled in primary school Male/ Female	% share of household income 1975 - 85	
											Lowest	highest
	1960	1986	1960	1986	1986	1986	1985	1986	1985	1983-86	40%	20%
1. Bhutan	297	202	186	130	1.4	54/11	160	40	—	32/18	—	—
2. Bangladesh	262	193	156	121	103.9	4428/854	150	49	43/22	70/50	17	45
3. Pakistan	277	170	163	111	102.9	4211/716	300	52	40/19	66/33	18	57
4. Srilanka	113	46	70	34	15.9	417/19	300	70	91/83	105/102	16	50
5. Maladives	—	91	—	68	0.2	—	290	—	83/82	—	—	
6. Nepal	297	202	186	130	16.9	677/137	160	40	39/12	88/44	—	—
7. India	282	154	165	101	772.7	22477/3455	270	57	57/29	107/76	16	49

Source: UNICEF, "The state of the World's Children - 1988".

3.
NEW ZEALAND

I present this report to you from the perspective of being an indigenous person in New Zealand, as a Maori woman and as a person of Ngai Tahu descent. I am employed by the Ngai Tahu Tribal Authority and am working towards establishing and co-ordinating a tribal plan to take us into the 21st Centurty.

BACKGROUND

Population

At the last official census in 1986 the Maori population made up 12.3% of total population of New Zealand, at a number past 400,000.

The Maori population is continuing to grow at a slightly faster rate than the Pekeha population although there has been a sharp decline in Maori fertility over the last 20 years. At the beginning of sixties Maori women were bearing an average of more than 6 children each. Today the average is just 2 children each.

There are no doubt many reasons for this decline, but the most likely reason is economics. Maori families simply cannot afford to have more children.

In 1988 60% of all Maori births were to women under 25 years of age. One in every 5 births today is to unmarried teenage mothers.

Maori mortality still exceeds Pakeha. Life expectancy is 7 years shorter for Maori male and 8.5 years shorter for females. Among adults too many deaths are occurring as a result of various forms of heart disease, respiratory disease, asthma, and motor vehicle accidents.

The Maori popuation is a young population. At the 1986 Census 62% of all Maori were under 25 years of age compared to 39% of Pakeha while at the other end of scale only 2% of Maori were aged 65 and over.

Urbanisation of the Maori

Probably no other change this century has had such a profound impact on the lives of Maori people, as their movement from rural areas to the cities. The urbanisation of Maori is thought to be one of the most rapid anywhere in the world.

The social, economic and cultural effects of this change are immense and are at the root of many of the problems Maori face today.

In 1925 about 80% of Maori lived in rural areas, now 80% live in the cities. The reasons are well known, what little land was left to Maori was no longer economical to support the growing population so they went to the cities to look for work, a move that was encouraged by Government who wanted to assimilate the Maori.

At present there is a political thrust to changing the structures of New Zealand and this has brought about significant changes for Maori people, which affects their well being and wholeness.

An Historical Perspective

A Treaty, the Treaty of Waitangi was signed in 1840 between the Crown's (at that time Queen Victoria) representatives and the chiefs of the tribes of New Zealand.

For Maori, the Treaty articulates their status as Tangata Whenua (indigenous people) guarantees their rights with respect to land, water, forests, fisheries and other treasures and confirms their rights to mana motuhake (self determination).

The signing of the Treaty by both Maori and European was seen as the recognition of a partnership of equals and the basis for relationships betwen two races. Implicit within the Treaty were the concepts of equity, partnership, cultural and economic security.

However, since the signing of the treaty, the political structures have either ignored the content, argued the principles or established legislation to suit themselves, ignoring the needs of Maori.

Present Situation

The need for Government to sanction policies that enhance the life experiences of Maori has long been recognised. There has been growing disenchantment with the quality of services that have been offered them. Increasingly educators are articultating their concerns about the quality of service for Maori people.

The Government has responded to Maori dissatisfaction by diverting attention from political powersharing, by offering

financial development funding and offering Maori leaders political patronage, which sadly some have bought.

A few years ago Government set up Corporations to replace some of its Departments.These Corporations were still run in much the same way as before, but employed many less poeple.

In December 1986 new corporations were formed under a new act called the State Owned Enterprises Act. These Corporations were to be established similar to private companies. They included : Coal, Land, Forestry, Railways, etc.

The Government then sold off these valuable resources to private companies who can do as they wish with these assets without references to the people. When this was established no attention was paid at all to the Treaty of Waitangi which guaranteed Maori Land protection, but now tribes are taking cases to the High Court of New Zealand to establish their rights.

Less workers are required to run these corporations. This has been particularly so for Maori because we tend to be employed in industries in the primary and manufacturing sectors ie: manual work rather than in the growing industries and occupations in the service sectors.

A New Zealand Maori professor suggests that the status of Maori mental health can be illustrated by looking at unemployment figures and educational qualifications. The validity of such examples is supported by his assertion that health is inseparable from social encounters, agriculture and environment.

HEALTH PERSPECTIVES

Te Taha Tinana : Impact on Land

The impact of land is crucial to mental health. Taha Tinana encapsulates the relationship Maori have with it. The earth known as Papatuanuku (earth-mother) bore and nurtured the first human form. In this way it was believed that land was an integral part of the individual. This belief forms a foundation for the view that land provides a secure footing (Turangawaewae) from where one can rise with the past. The individual that has lost his/her tribal lands is an individual divorced from spiritual sustenance. This ideology underlies the fervour with which Maori are pursuing promises made in the Treaty of Waitangi.

(Explanation given here of Waitangi Tribunal and Ngai Tahu Land and fishing claims).

Te Taha Whanau : Impact of Family

The Maori concept of family is broad. It goes beyond immediate kin to encompass a structure that is broadened by the age of family members and the dimensions of the family sub groups. Traditionally the individual existed within a core family group. At each level these communites operated as a co-operative unit that is bonded by blood. These family units (whanau) are essential to wellbeing.

Te Taha Wairua : Spiritual Wellbeing

Te Taha Wairua is that non-material spiritual "vital essence" part of the person. It is the life force that determines who you are, what you are, where you come from, where you are going to, and provides the vital link with ancestors who are perceived as omnipresent. Spiritual wellbeing is extremely important for Maori and is acknowledged in their every day lifestyle.

Te Taha Hinengaro

Te Taha Hinengaro refers to the values that determine good social conduct: awhina, manaaki, taki and aroha are accepted and advocated. These values of love, assisting, respecting and strengthening empower the whanau groups.

Importance of Maori Language

Language embodies concepts relevant to mental health. Without language, expressions of state of health are severely restricted.

Maori relied heavily on their spoken language to express emotion. The Maori language has been denigrated so conceitedly that it is no longer the mother tongue in New Zealand. Many Maori have been denied the opportunity to use a skill that significantly enhanced their wellbeing. Others have been denied the opportunity to develop it.

The importance of language is further emphasised when it is realised that lanaguage and emotion were considered to be inseparable. Language allowed individuals to articulate their state of wellbeing as much as its use, indicated to another how emotionally healthy the individual was.

(Explanation of Te Kohanga Reo movement and the impact it has had on Maoridom).

Maori Perspectives on Education

Maori educationalists assert that the education system continues to disadvantage Maori students. The figures tell us that 55% of Maori students, who left school in 1986 had no academic qualifications seemingly required by the system. By contrast 50% of non-Maori school leavers had achieved the required qualifications.

Maori have little power over the kinds of education opportunities they have been given with mainstreaming.

What I have been trying to indicate to you is that in traditional Maori terms, health is an all embracing concept which emphasise the Wairua (spiritual), Whanau (family), Hinengaro (mental) and Tinana (physical) aspects. Modern terminology refers to this concept as "Holistic", which contrasts with the traditional western model in which the physical aspects of health and sickness are emphasised.

In order to achieve any improvement in health, health initiative must incorporate a holistic definition and be part of the development strategy, to improve the overall status and wellbeing of the Maori community.

(Explanation of some Health initiatives, eg Marae based, monitor programmes and involvement in traininng programmes).

WHAT DOES THE FUTURE HOLD?

The challenges as I see them are:

- The three Articles of the Treaty to be regarded as the foundation for good health for all in New Zealand.
- Maori tribal authorities to be recognised as the proper trustees for Maori.
- Resources to be made available to enable Tribes to establish tribal development plans including all the aspects important to the people.
- Maori issues can only be addressed by involvement of greater number of Maori in the delivery of services.
- Training programmes reflecting the bicultural nature of New Zealand instead of the tokenism which is present at the moment.

During 1990 the Government is preparing for celebrations and commemorations of 150 years, since the signing of the Treaty of Waitangi. This will present opportunities to highlight

and focus on the issues of justice raised by the Treaty and to bring pressure to bear on the Government for recognition of the Treaty, as a basis for the judicial system the economic structure and social life of our society.

For most Maori the reality of life is political powerlessness and economic oppression.

We have an attitudinal problem of dependency. We have become dependent on the state.

The land issues have become dominant, its local expressions are: unemployment, poor health, poor housing, poor education and a loss of self esteem.

WHERE ARE THE CHURCHES IN ALL OF THIS ?

Although many members are active in the anti-racism field and increasingly, attention is being paid to arousing Pakehaa awareness of the Treaty and its implications in terms of bicultural partnership, we seldom, if ever experience the Church objecting to economic policies which promote and encourage materialism.

I feel, for all the above, the wheels of change are just begining to turn. In 1984 there was a very strong lobby for Government to provide the resources to let Maori develop their own programmes. Some areas have picked this idea up and developed programmes of their own.

(Explanation of Kaikoura's 'Whale Watch', Moeraki's attempts to buy a farm for the purposes of training their young people).

On a more global scale, New Zealand has other issues to grapple with:

— New Zealand has taken a stand to be nuclear-free.
— Drift-netting within the waters of the Pacific is klling many, many fish and bird life of all kinds.
— Ozone layer damage and its implications.
— Cot deaths amongst our babies.
— Elections 1990 - racism maybe one of the major platforms, brought about because of land and fishing, and bad media reporting.
— 1990 Commonwealth Games - Threats of boycott.
— 1990 Celebrations of signing of Treaty of Waitangi - Many Maori will not be participating.

— Women in New Zealand are becoming more political and slowly gaining recognition for their contributions.
— In December 1990, an Indigenous Hui will be held in New Zealand. The theme being "Sharing Together".

Finally I wish to thank Christian Church of Asia for allowing me to participate in this consulation. I have learned so much in two days, my mind is overwhelmed with the stresses and the pain many countries are experiencing, but I am encouraged by the participation of you all.
Kia or a koutou katoa.

KOA MARHSALL
New Zealand

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4.
AUSTRALIA

I come from a land of sun and spaces. A land of some 16 million population. I come as a white colonial, bringing with me a dubious legacy of colonial domination. I want to share and confess the dis-ease, the injustice, the annihilation of the Australian Aboriginal people. I am part of that destrcution. I so confess.

The history of Australia and the Aboriginal people is a bloody one, a bad and inhuman one. The late 1800's saw the arrival of convicts from England. They came to serve their jail terms in this new colony. For many convicts the only crime was the stealing of food for their starving families. These "criminals" were accompanied by the military, and together came the settling of a new colony.

A negative beginning for the convicts, but an even more devastating one for the indigenous Aboriginal people who had known their home in this same land for over 40,000 years. With colonisation these Aboriginal people were hunted, tortured and killed.

The colony developed; as did the power and authority of the military, the government and the church. Time passed. Housing settlements and towns came into being. As the convicts served their time for their crimes, they too were able to obtain lands and begin a new life. Industries were formed, governments constituted and churches consecrated. Progress!

For the Aboriginals, however, the picture was devastatingly different. They endured decline in population, health, esteem and value. The white settlers acted out their "assumed" superiority and denied the Aboriginal people their rights and dignities as human beings. They were thought of as black savages, uncivilised and inferior. As such, they had no power, authority or recognition. They had lost their rights to their lands and were thought of as strangers and intruders in a land they had lived in and loved for so long, and which was integral to their identity and being.

After such a dubious beginning, the question must be asked - how is it now for the Aboriginal people? 1988 was the Bi-centenary of white settlement in Australia. The government announced it as a time to celebrate the birth of a nation, a time to be thankful for where we'd come from to where we were now, and what we'd gained along the way.

The Aboriginal people were angered and disgraced by the suggestion of a celebratory theme. Why should they celebrate? What could they celebrate? For 200 year they had been treated as second class citizens at best and animals at worst. The legacy of 200 years of white settlement brought much to the Aboriginal people. They experienced higher mortality rate among babies and children than that of the white Australians. Disease in general was alarmingly high among the Aboriginal people. The consumption of alcohol and tobacco brought their own devastation and consequences upon the quietly spiritiual Aboriginal. Isolation from their tribal land and the losing of sacred sites was a legacy bestowed upon the peoples of the Aboriginal tribes. Mining Companies (and others) were quick to recognise the monetary possibilities of these lands, so they were able to reap the profits and call it progress.

There seemed also to be little understanding or interest by white Australians in the cultural norms and spiritiuality of the Aboriginal people, expressed through their love affair with the Earth. Within the Aboriginal culture there are stories which simply, yet vividly, tell of the hopes and dreams of this "Earth people"; a people "at one" with nature, where life's meaning is found in community and in one's relationship to the land. As such, the Aboriginal people are a deeply spiritual people. Sadly this spirituality is not understood or tolerated by the white Australian people.

Today, one year after the Bi-centenary, what has changed? The first thing I'd like to mention is confrontation. During the preparations to the Bi-centenary and during the year of "celebration" there was a lot of confrontation between white Australians and Aboriginal Australians. There was also conflict between white Australians and white Australians, Aboriginal Australians and Aboriginal Australians. The Bi-centenary proved to be a catalyst where issues and emotions were brought out into the open; racism and bigotry recognised for what it was; angers were allowed to be expressed: injustices acknowledged and shattered hopes and dreams shared. Although this was a painful experience, I can only feel it was a positive one, as it offered a legitmate forum for issues and feelings to be expressed from all sides.

What else has changed? Before, during and since the Bi-centenary, there has been a *firming in the organisation and structure* of the Aboriginal people. They have rallied together and

formed themselves into effective education, sharing and action groups. The positive outcome of this formal organisation was that marches were held; education was offered concerning Land Rights issues, and a forum given for the issues of justice, equality, health and wholeness to be dealt with.

As a result of this, the Aboriginal people have become more vocal and more confident. At least their cry for justice and recognition has been heard by some. Another positive outcome of this is that impetus has been given to the white Ausralians' recognition of Aboriginals' just claims for the return of some lands and sacred sites.

In a very clear and dramatic way, the voice of the Aboriginal people could be heard above the sounds of the celebration of a Nation - and this was good. But yet the fight continues on beyond the Bi-centenary for the rights and privileges which belong to the Aboriginal people.

The third change I'd like to add is that of *confession*. With the Bi-centenary, many churches (as well as the individuals within the churches) were divided in how they should respond to the Aboriginal call for justice and equity. They were pulled between conscience towards the Aboriginal people and also their desire to join the Birthday celebration of 200 years. Doesn't everyone like a party? Many churches called for a Litany of Confession which could be offered to the Aboriginal people - and to God, for the injustices incurred. For many this was seen as a time for healing; a time of reconciliation. For many it was felt that we could only celebrate our wholeness as a nation, when we recognised the disease within ourselves and others, when we acknowledged our human frailty and when we expressed our desire to be made whole in the image of Christ.

The image of the Rainbow is for many a symbol of hope. It is of special significance to the Aboriginal people. Being at one with land they see that they are part of God's hue, as they celebrate the diversity and the grandeur of creation.

As a christian, I owe my spiritiual being and healing of my personal memories and social relationships to the brokenness of Jesus Christ. As an Australian, I owe my physical presence and the benefit of the land to the brokenness of the Aboriginal people.

The brokenness and resurrection of Jesus Christ is vindication of my faith and hope. The brokenness and resurrection

of the rainbow people will be found in the vindication of their culture and their history.

With the restoration of the Aboriginal culture and human dignity will come the healing of corporate memory and the beginnings of truly human relationships so that Australia can be a land of truly rainbow people

REV. RUTH O' SULLIVAN

• • •

This presentation is one that was given at the cousultation. It contains no statistics it comes straight from the heart.

Appendix I

Consultation On The Healing Ministry

OPENING WORSHIP
13th November, 1989

CALL TO WORSHIP

Leader : Those who are led by God's spirit are God's children. For the Spirit that God has given you does not make you slaves and cause you to be afraid; instead, the spirit makes you God's Children...Rom.8:14

People : We believe in God,
who dwells within us,
who strengthens and guides us
to be a free people,
to fulfil our human responsibility,
to reach out to our neighbour,
to heal a broken world
and to rejoice in a life shared with others.

Leader : "Come to the Lord and as living stones, let yourselves be used in building the spiritual temple to proclaim the wonderful act of the Lord who called you out of darkness into God's light... At one time, you were not God's people, but now you are the people of God; at one time, you did not know God's mercy but now you have received mercy." I Peter 2:4 ff

People : We believe in God - who has called us into a community of faith - to witness to God's love, to celebrate God's presence in the world, to struggle for justice and peace and to bring wholeness to life.

Leader : "Then the one who sits on the throne said Behold I made all things new. It is done! I am the first and the last, the beginning and the end. To anyone

who is thirsty, I will give the right to drink from the spring of the water of life without paying for it. I will be their God and they my children."

Rev.21:5

People : We believe in God - in whom the whole creation would be restored; God will overcome all forces of death. We believe that our destiny and the destiny of every person is within God's love. Finally God's love will rule all life.

HYMN "Worship The Lord"

PRAYER

Lord, there is always suffering and sickness around us
We don't understand why this is so, it is a mystery to our minds.
We only know you care, that you ask us to walk through the valley of the shadow of death.
Holding the hands of the ones we love, listening to you and holding your hands ourselves.
Lord, you are the giver of life.
In the midst of suffering
we celebrate the promise of your peace.
In the midst of oppression
we celebrate the promise of freedom.
In the midst of doubt and despair
we celebrate the promise of faith and hope.
In the midst of fear
we celebrate the promise of joy.
In the midst of sin and decay
we celebrate the promise of salvation and renewal.
In the midst of death
we celebrate the promise of eternal life.

THANKSGIVING

L : Lift up your hearts.
P : We lift them up to the Lord.
L : Let us praise and thank the Lord our God.
P : It is right to praise and thank him.
L : Let us pray.

O Lord Jesus, we thank you for coming to this world among us that we are all one and at the same time, that we are brothers and sisters of a family. Lord Jesus, it is you who brings us together, peoples, from different nations of Asia, people belonging to various cultures here today to build an everlasting unity and solidarity and ever better understanding so that we can share with the suffering and struggling peoples of Asia in truth and love. O Lord Jesus, give us courage, perseverance and strength for this very end.

P : AMEN.

THE WORD

Mark 3. 13-20

RESPONSE TO THE WORD

PENITENCE

All : Everloving God we acknowledge in your presence that we continue to live in bondage;
as individuals -
to misplaced priorities
to ethnic loyalties
as a church
to self-centredness and lack of vision
to division and disunity
as a society -
to apathy and hopelessness
to the status quo and sinful structures
Foregive us, O Lord, and accept us as your children, through Christ our Lord.
Amen.

RESPONSE : Kyrie Eleison

AFFIRMATION OF FAITH (Together)

We believe in one God,
Author of life, Creator of the universe.
We believe in the Son, Jesus Christ our Lord,
who came into the world to seek the lost
and to redeem the whole creation.

We believe in the Holy Spirit, the Giver of Life,
who leads us to all truth,
renewing us and enabling us to grow
in the likeness of Christ.
We affirm the dignity of all who live in the world
and the basic right of all human beings
to develop as children of God
for whom Christ has given Himself in love.
Our hope is in Jesus Christ
whose purposes are fulfilled through his people.

HYMN "Ever And Always Be Praise"

BENEDICTION

L : May the God of love who shared his love and life to us
strengthen us in our love for others.
grant us grace that we might share our life and empower
us to be only and always for others.
P : AMEN.

SENDING FORTH

L : With God's love deep in our hearts,
His wisdom to know and understand,
His Spirit stirring in our souls,
His power to care and share,
Let us go forth in peace into a new day.

P : AMEN! AMEN! SHALOM! SHALOM!

Consultation On The Healing Ministry

CLOSING WORSHIP
17th November, 1989

PREPARATION

CALL TO WORSHIP

Leader : Come, let us, with one voice, worship God.
People : God is worthy of our united praise.
Leader : We come to confess our divisions and celebrate our unity in God.
People : We rejoice that from our separate lives God has gathered us into one great fellowship.

HYMN "We Are One In The Spirit"

PRAYER (together)

God of our successes and our failures, our ups and downs;
God of our endless struggles and our never-ebbing strength.
We celebrate all those whom you have called again and again
to offer themselves, even their lives,
for the building up of your community of shalom,
however, meagrerely.
And now, bless us, O loving Parent,
As we dance in affirmation of all that you are doing,
through us or despite us,
for the sake of the love that must ultimately
reign among us and all of the world. In Jesus' name
AMEN.

THE WORD OF GOD PROCLAIMED TO THE COMMUNITY

RESPONSE TO THE WORD

PRAYER OF INTERCESSION

Leader : 'A Caring Community' and 'A Sharing Community' are two expressions used down through the centuries to describe the nature of the Christian community. One of the supreme ways in which these concerns to 'care' and to 'share' receive expression in the church's life, is in its intercession for the world. It is here - in the act of intercession - that the Church identifies itself with the sufferings of the world and stands alongside the world looking up to God,

In our intercession today, we shall use the familiar spiritual "Kumba yah, my Lord", for this spiritual has touched the hearts of many nations and cultures. It is an agonizing cry to God to "come by" - to stand along with - those who, in desperation and hope, raise their voices to God.

People : (sing) "Someone's crying Lord, Kumba yah (3 times) Oh Lord, kumba yah."

Leader : Someone's crying Lord, somewhere
Some is millions, somewhere is many places.
There are tears of suffering,
There are tears of weakness and disappointment,
There are tears of strength and resistance,
There are tears of the rich and the tears of the poor...
Someone's crying Lord, redeem the times.

People : (sing) "Someone's dying Lord, Kumba yah (3 times)
Oh Lord, kumba yah."

Leader : Some are dying of hunger and thirst,
Someone is dying because someone else is enjoying too many unnecessary things.
Someone is dying because people exploit one another.
Some are dying because of structures
Which crush the poor and alienate the rich.
Someone's dying Lord, because we do not know how to share, how to choose, how to witness.
Someone's dying Lord, redeem the times.

People : (sing) "Someone's shouting Lord, Kumba yah (3 times)
Oh Lord, kumba yah."

Leader : Someone's shouting out loudly and clearly.
Someone's made a choice.
Someone is ready to stand up against the times.
Someone is shouting out,
Offering their very existence in love and anger
To fight the death that surrounds us,
To wrestle with the evils with which we crucify each other.
Someone's shouting Lord, redeem the times.

People : (sing) "Someone's praying Lord, Kumba yah (3 times)
Oh Lord, kumba yah."

Leader : Someone's praying Lord -
Praying in tears and anger,
In frustration and weakness,
In strength and endurance.
Shouting and wrestling,
As Jacob wrestled with the angel -
And was touched, marked and became a blessing.
We are praying Lord.
Touch us, mark us, make us a blessing,
Let your power be present in our weakness.

People : (sing) "Someone's sharing Lord, Kumba yah (3 times)
Oh Lord, kumba yah."

Leader : Someone's sharing Lord,
Sharing their needs; sharing their riches;
Sharing their pains; sharing their joys;
Sharing their goods; sharing their lives.
Someone's sharing Lord. Teach us also to share.

People : (sing) "Kumba yah my Lord, kumba yah (3 times)
Oh Lord, kumba yah."

Blessing

Leader : Go in peace to love and serve the Lord.

People : In the name of Christ, Amen.

HIGHLIGHTS OF THE BIBLE STUDY

Luke 7:18-23

(Rev. A.C. Oommen)

1. The concept of the Kingdom is that of a new creation - something fresh/revolutionary. The community was at the center of biblical understanding. Presently, we are losing community because of individualism. Jesus' response of restoration for the blind, deaf, lepers and the raising of the dead signifies restoration of cut off relationships and bringing life to the community.
2. Healing is not an individualistic experience. It is restoration into the fellowship.
3. The whole message of healing is to be understood in the healer itself. We recognize the Messiah through the restoration of human relationship.

Different Emphases of Healing In The New Testament

1. Synoptic view (Luke 4:16-21)
   The image of perfection/fullness is that the power to be whole comes to us by the death and power of the resurrection.
2. St. John's view (John 10:10)
   Healing is restoring a person to the purpose that God has created him/her. The quality of life is in the discovery of its meaning and purpose.
3. St. Paul's view (2 Cor. 5:17-20)
   In Christ, there is a re-creation of the relationship of the whole concept and values. Jesus Christ ushered the new world of relationships. We can only be whole if we are instruments in making others whole.
4. View from Hebrews - Barnabas (Hebrew 10:19-25)
   The verses reveal the uniqueness and greatness of God. In adoration, we are united within ourselves and restored to God. We are cleansed and restored. We need to encourage each other to love and good works. Healing is towards a purpose and not an end in itself.

The challenge is for the whole body of Christ to be transformed and for the congregation to be healed so that the church is able to heal those who touch or come in contact with her. The healing ministry is not a service; it is a proclamation of action; it is a restoration of relationship; it is a dynamic force.
John 20.19

The day of resurrection is the most eventful day - the day that changed history. It inaugurated a new world.

Three things happened that day (John 19:19):

1. Evening has come.
2. Doors were shut.
3. Disciples were full of fear.

In what better words can we describe our churches!!!

Jesus Christ, our Lord, appeared in the midst of His disciples and showed his credentials - the wound marks on His hands and sides - eternally left in the body of Christ. Peace/ Shalom was declared. In the whole ethos of Hebrews, there is no place for abstract thinking. Shalom is harmony with nature, with God, with neighbour.

1. The language/method given to us is the language of the cross - the secret of our power is our powerlessness.
2. We are enabled to do that through the power of the Holy Spirit. The sign of the Holy Spirit in us makes us willing to identify and meet people in their suffering.
3. Christ bids us to go out. The church cannot exist for itself. It is in coming together - to seek the situation outside and to feel the wound and the pain that we participate in the wholeness of creation. We are wounded healers. In becoming poor and encouraging the poor/ marginalized/suffering, we experience the cross of Christ. It is the place of our glory - not our shame. It gives strength, hope and assurance that with the cross, the Lord is our strength. The struggle for humanness is the struggle of Christ.

Recorded by:
Erlinda Senturias
30 November 1989

GROUP DISCUSSIONS

4 groups take up one major theme with five specific questions to help them.

1. Church and the Healing Ministry

1) What is your theological understanding of the healing ministry?
2) What is the role of church in the healing ministry?
3) What is the place of the healing ministry in the mission of church?
4) In the light of our theological understanding of the healing ministry, what is the role of Christian as well as non-Christian institutions of health?
5) How can the CCA and CMC/WCC cooperate in helping the churches and other institutions to understand/undertake the healing ministry in Asia?

2. Health and Social Justice

1) What is the orientation of your organization/institution/program/congregation on the whole question of relationship of health and social justice?
2) What are the manifestations in practice of such orientation/philosophy behind your institution/programme/organization/congregation?
3) What facilitates/hinders the implementation of your idea/orientation philosophy?
4) What new ideas emerged from your initial understanding of health and social justice?
   e.g. a) community vs. individual rights
   b) value system
   c) education for critical consciousness
   d) class analysis
5) How can various groups grow together towards health and justice. Is this possible given the various spectra of ideas. What will be the lay strategies to carry this out in the following levels?

CCA
National Ecumenical Agencies
Member Churches/Congregation
International Agencies
Individual health advocates

3. Education and Training in the Healing Ministry

1) How do you see the concept of Education in Health within the wider concept of Education?
2) Identify specific types of formal and non-formal training in the healing ministry in which Churches and Christian organizations are involved in Asia.
3) List possible strategies of formal and non-formal health training at Asian level, Subregional level, National level and local level.
4) Identify various community healthy training curricula and common strategies which could be used at the various levels of cooperation.
5) What practical steps (strategy) could be found to stimulate theological, medical and nursing schools to incorporate the healing ministry into their curricula?

4. New Emerging issues in Health & Healing Ministry : Beyond Institutions, health care and services.

1) What are the new emerging issues in health and healing ministries in Asia? List them and attempt to group/prioritise them.
2) How can the Church be more involved in health and medical ethics? What are some of the problems?
3) In the context of the wider understanding of health, healing and wholeness, what can the churches of Asia do under the theme Justice, Peace and the Integrety of Creation?
4) How could the Church handle problems related to some of the following issues?
   - Women's health
   - Rational drug therapy
   - Drug and alcohol abuse
   - Broken homes, families, persons and relationships
   - Aging

— Death and Dying
— New Epidemics Eg. AIDS
— Mental problems in society

5) What common areas for cooperation, advocacy and support are there for the Asian Churches in the above questions? Suggest strategies for coordination, common action and linkages at various levels.

5) Strategies for Cooperation and Sharing in Health/ Healing Ministry (Discussed by all groups)

1) Why should there be greater cooperation, sharing and growing together in Asia for the churches in health, healing and wholeness?
2) In what ways can there be greater sharing-within nations, at sub-regional, and Asian levels? Suggest activities and structure for the same.
3) What can the Asian Churches contribute to South-South dialogue in healing ministries between Asia, Africa and Latin America? How can this be done?
4) Identify areas where your churches can give and receive from others in Asia in the healing ministries.
5) How should Asian Christians work in health & healing ministries in the context of Government health programmes, secular health agencies and countries where the church/ecumenical structures are very weak?

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CCA Consultation on the Healing Ministry
Nov. 11 - 17, 1989 Bangkok, Thailand

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I
THE CHALLENGE FOR CHRISTIAN HEALTH WORKERS IN INDONESIA

I. It is neither preventive or curative, but 'total health care'

The problem whether curative or preventive medicine is more importent in health service has been frequently made a topic of discussion. It has often been stated that we must give a prominent place to preventive medicine rather than curative medicine. *It is better to prevent disease than to treat the sick.* This view is quite right, but essentially the important thing is not what should be given first place, preventive or curative, but the horizon of the problem. The definition of health has been changed. WHO has formulated that HEALTH is not a mere absence of disease and weakness, but a state of complete *well-being*, physically, mentally, and even socially. (Christian health workers are convinced that there needs also to be *'spiritual well-being'* in order to be healthy).

The debate as the prominence of curative or preventive medicine has lost its urgency, because the new horizon unfolded by the definition presented above has placed the problem in a different light. The approach to a healthy life cannot be carried out through curative and preventive service alone, but should be total and complete. This *'total health care'* includes preventive, curative, rehabilitative and supportive service, aimed not, merely to restore the wholeness of the body, but the mental, spiritual, and social life of man as well.

The view that we should give prominent place to preventive medicine among the poor strata of community is a rather fallacious one and can be interpreted as an effort to move away from a complete approach, of *'total health care'* of the poor.

Ideally, we must state that the opportunity to receive total health care should be equal for everyone, irrespective of his status. The problem of providing opportunities and facilities of *total health care* cannot be viewed separately from the inavailability of those facilities and opportunities to a large part of the less-well-to do in the Indonesian community.

II. Primary health care deserves priority

A problem of common concern nowadays is the distribution of health service, both with respect to the provision and the accessibility of the service. The Alma-Ata Conference in 1978 has formulated the world's concern about the inequality of distribution of health services, even of their most essential elements.

Primary health care is precisely the service deserving priority by all nations of the world and its development is their common responsibility so that the state of '*health for all by the year 2000*' will be realized.

Primary health care is the central function and main focus of the National Health System and of the entire social and economic development of the nation as well. This service is aimed at the basic health problem in the community and comprises the provision of suitable promotive, curative, preventive and rehabilitative health services.

Primary health care must at least include :

— Education in general health problems and the ways of their prevention and solution.
— Improvement of nutrition and provision of healthy drinking water and basic sanitation.
— Mother and child health care, including family planning.
— Prevention and control of local endemic diseases.
— Appropriate treatment of common diseases and injuries.
— Provision of essential drugs.

To achieve its goal, primary health care does not involve the health sector alone, but all other sectors related to the aspects of social and national development, especially agriculture, cattle breeding, food production, industry, education, housing, public works and communication, and requires coordination of all those sectors.

III. The inequality of health service

The uneven distribution of the state of health caused by the unequal distribution of health service is affected by a variety of factors, among which are:

1. The concept of wholeness of service and wholeness of service targets. The wholeness of service is the wholeness of service provided, not subject to fragmentation into curative, preventive, promotive, and rehabilitative services. The wholeness of service targets is to see man as a whole,

i.e. not fragmented into his constituting elements : body-mind-spirit, and not still further breaking down the body into ears, skin, hairs, etc. Neither is man whole by tearing him away from his unity with his social and natural living environment.

2. The factor of *'distance'* between the provider of service and the recipient of service. Distance here should be understood in a broad sense, e.g. :

   a. Geographical distance : the service providers are concentrated in the towns, whereas a large part of recipients live in the villages.

   b. Economic distance : economic distance constitutes a separating curtain between provider and recipient, taking the shape of high tariffs, high costs, poverty etc.

   c. Cultural distance : due to different patterns of thinking and education as a background, polarization emerges between modern-urban westernised health workers and the traditional-rural community.

   d. Policical distance : it refers to who are the decision makers and to the right of the community to participate in planning, executing and evaluating their own health services.

3. The industrialistic and *'profit oriented'* pattern of health care services. This pattern has adverse effects on the community of employees and workers and the ethical code of work, and contributes to the effects of aforementioned factors.

4. The inequality in other spheres of social life directly or indirectly gives rise to inequality of the distribution of the state of health.

Aforementioned factors exist at the same time; they form an integrated whole and mutually strengthen one another. So, the view that poverty or economic weakness constitutes the main obstacle is not quite true.

IV. Community based programs

The problem of inaccessibility of health services to a large part of the Indonesian community has been a cause of common concern. The Government has established CHC's in every district to bring the health services close to the community, locating the center in places where people live and work. CHC's has been established as the bearer of responsibility of the state of health in their respective regions of duty and provide primary health service to the local community. But, it has become common knowledge at present that the provision of service facilities in the villages with small fees does not solve the problem.

The essence of the solution of community health problem anywhere does not depend merely on the provision of facilities and ease of access thereto. The essence of the problem is who has the rights and bears the responsibility of solving the problem. We as workers in health service feel that the rights and responsibilities to render service - planning, executive and evaluating - are ours. We create institutions and health service activities for the community, and even create an atmosphere of dependency of the community on the services we have built up. We create a complex service and a costly and *'sacred'* one too, establishing prohibitions presenting as our reason that it is at the disposal of *'doctors alone'*.

The structure of health service at present is greatly dependent on *'institutions'*, frequently referred to as institution based service. Within such a structure the role of the institution is very dominating, and the same applies to the workers of the institution. This creates a very strong dependency so that the community cannot do anything without the institution. The right and duty of the community and its members are castrated and taken over, and a very strong dependency remains very strong so that people cannot enjoy health treatment without insurances and hospitals.

The right and duty of the community with respect to their own health must be given back. Community groups and their members must participate in planning, executing and evaluating their own health services. In this way the efforts to improve health service do not merely comprise the provision of opportunities and facilities for the community, but also involve the restoration and strengthening of its role in this undertaking.

Primary health care is more than helping the community or providing services; it is the *'transformation'* of the community

and the structure of health service existing at the present time. The institution based pattern of service must be transformed into a *'community based'* service.

According to the community based service we are no longer oriented towards the project or program we have developed ourselves, but we must direct our attention to the program developed together with the community and based on problems of the community. This is called a transformation from a project orientation toward an *'issue orientation'* in planning.

Neither should we direct our attention to the results achieved, but we should rather value the processes taking place in the community. This is referred to as a change from *'achievement orientation'* towards *'process orientation'* in evaluating.

V. The relation between governmental and private service

In the concept of CHC in Indonesia is contained the understanding that this body bears full responsibility of the health situation in the region concerned. So, the CHC is not the sole agency providing services. Other agencies, the private sector in particular can also render services, but not in the sense of bearing responsibility of the healthy situation of the region. Many people wrongly think of the CHC as a cheap health clinic in the village or a location for vaccination. The CHC is a primary health care system vested with Governmental authority.

Conceptually, the establishment of CHC's is samething worthy of praise and in this respect Indonesia is frequently considered more advanced than other developing countries. The sole weakness of this concept is the entry of Governmental authority into it. The approach of service becomes too vertical; the working programs are based on projects designed centrally, owing to this weakness, a good CHC worker will realize that he needs private effort which actually represents the embodiment of community initiative. We do not need to mention other technical deficiencies occurring at present, e.g. the lack of funds, staff, drugs, etc.

A law regulating the CHC is not-existent yet, rules are being put in order and there are number of private bodies running CHC's. But Socio Pastoral Bethesda views the problem differently, as it is not its task to spread its wings by establishing new institutions in the villages.

Socio Pastoral Bethesda feels called upon to help restoring the community's rights and duties to handle their own health

service. Socio Pastoral Bethesda will not create new projects and persuade the community to participate in making them a success, but Socio Pastoral feels called upon to participate in programs owned by the community. Socio Pastoral Bethesda does not compete with the Government, but on the contrary, even lends a helping hand to fill a vacuum resulting from a stiff central approach. It is not Socio Pastoral Bethesda or its programs which are present in the villages or community groups, but it is the efforts of the community itself which are present, whereas Socio Pastoral Bethesda may or may not render help.

II
A BRIEF REPORT FROM A SMALL GROUP DISCUSSION ON BIBLE STUDY I

1. Discussing the difference between "Curing" and "Healing" (for wholeness), our group noted that the concept of "curing" is limited and partial in its content. This implied "mechanical" or even merely "scientific" aspect of the process of healing of the humanperson. "Healing" on the other hand, embraces the whole of the human person - body & mind and spirit or soul. Further "Healing" extends beyond the individual to the cluster of persons in family and yet beyond to the Community. This is to say that "Healing" is at once an "inclusive" and "Cluster" experience. This implies "inter dependence" as against "dependence" of the individual seeking and receiving "curing" from the doctor or the hospital. "Healing" as a concept, therefore, implies growing or moving towards *"self-reliance"* of the person that makes for restoration of personhood of the sick person or the victim of ill-health.

2. To confirm and substantiate the above understanding of "Healing" as revealed also in the Bible Study from new testament texts - two stories were cited by one handicapped christian lady and by another lady medical doctor:

Ms. Lee of Korea a polio-victim from the age of 3 years, shared a bit of her own story.

Ms. Lee refered to her attendence at church in Seoul, Korea Sunday after Sunday - with great physical effort even with her crutchs-climbing steps that led up to the front entrance which also needed to be negotiated while returning back from church service. Each Sunday she had to depend on some volunteer, young or old, man or woman who happened to be there nearby at that time but she totally detested such *'dependence'* on those good hearted christian brothers and sisters. The deacons, pastors, evangelists etc. of the church seemed to have no idea of her needs or of the other physicially weak like old people and other handicapped people going to this church. Why did they not think of building a ramp and a handle - beam to support these fellow christians to "independently" climb the steps to reach the church for worship? She and others like her felt totally "neglected" and ignored. What a failing of church's "Healing Ministry"?! she exclaimed.

The second story from Dr. Mesach of Indonesia refered to the case of a middle-aged lady who once came to this doctor saying "please help me, doctor; but I need no medicine for my ailment what I need is a place near you so that I can cry out my tears!" The sensitive christian doctor, showed her a room where that lady wept for more than an hour in her privacy and when she emerged out of the room the doctor touched her head affectionately also holding her hand for a while which seemed to have visibly released the visitor from all her pain, agony and ills that she came burdened with. Indeed, there was healing and wholeness for that person which came through the christian doctor.

III
A VOICE FROM A HIDDEN, HANDICAPPED WOMAN

LEE YEJA (KOREA)

I love this Bible passage very much because it gave me the reason to live.

Yes, I do not become a handicap; neither I nor my parents have sinned, but this happened so that the work of God might be displayed in my life. My encounter with this world gave me

the strength to overcome my frustrations as a handicapped person. I could pass my period of teenage.

I love our theme in this consultation "Growing Together, New Strategies for 2000." Church should prepare new strategies for the coming new era.

In the Asian context, churches have a big responsibility in the healing ministry, especially for the handicapped, because in the Western society, the governments are working for the needy in various fields, but not in Asia.

That's why Asian churches have more tasks to do for the people who are suffering. Understanding of the handicapped in the church is very low. I want to give you a very clear example to prove what I'm saying now.

A few weeks ago, my church was renovating the steps. When I went to go the following week, I found the steps became higher and looked more beautiful with marble. For me, it became more difficult to enter the church. So after worship, I complained to the pastors and assistant pastors who were in line to greet congregation members.

"Oh, why not fix something for me at the end of the side so that I may grab to step on."

One elder replied, "Oh, Miss Lee, you are so selfish. You are thinking only of yourself. If we fix something there, it won't look beautiful."

The other church leaders were only smiling at our talk. What does their smiling mean? They may say in their mind, "Hey lady, what nonsense are you talking about? You don't have any right to ask something to be done. You are the only one handicapped in our church."

The pastor may preach about the lost sheep. What does the church mean? Why should the church be here? Acording to my church's point of view, it should be here to show their beautiful construction, not the people. Of course, I can have worship with the help of people but why should I have help every moment? If the church considers a little about the weak people, including the elderly and the handicapped, the church will be a real church where God is present. If we exclude our brothers and sisters because of their handicap, how can God come into that church?

In Korea, the number of churches which consist only of handicapped people are increasing. The pastor of that church is

usually handicapped. In all parts of the church buildings the handicapped are not considered at all. The handicapped just feel they are not welcome in churches. So they are not coming to the church and the church cannot see the handicapped in their place. *These are only buildings, not churches.*

I want to bring this issue into our consultation as far as we are discussing the healing ministry of the church. What does that mean by integration and wholeness in God?

There cannot be wholeness and integration without the handicapped people of God. Do you know that? The handicapped are also creatures in the image of God. Jesus Christ died on the cross for them also, not only for you, the non-handicapped.

Let Asian churches say to the handicapped:

"You are my brothers and sisters."

IV
NEPAL : NATIONAL CHRISTIAN FELLOWSHIP (NCF)

I am from the land of the Gorkha and of Mount Everest. Nepal has never been colonised.

Nepal is a land locked and mountainous country with 16 million population. She has declard herself as a Hindu state. But there are people of other religions such as Budhists, Muslims and Christians. Every christian has a birth right to go for one years imprisonment, according to the law. Through sufferings the churches have been growing. Before 1965 there were very few christians who used to wander in search of other christians. In this background NCF was established in 1965.

There are a number of health problems such as alcoholism which causes family problems (broken homes), mental illness, drug addiction, leprosy and other problems. The medical doctors are centerd in cities. There are very few NGO's who are involved in tackling some of the problems. Due to restrictions and lack of knowledge of healing ministry, christian hospitals have not been able to do much.

The christians individually or the church itself have been involved in helping sick people to come to the hospital. The sick people are prayed for in their sickness. In eastern part of Nepal in some of the communities the gospel has spread because of healing.

Social work has been one of the concerns of NCF. Therefore, it plans to play a role of encouraging local churches (to assist local communites to meet their work for social work). It is not easy for any christian to assist non christians financially and materially along with the gospel. People look at christians very suspiciously. Because of restrictions Christian Hospitals stopped its gospel ministry. We believe that christians will grow faster without the presence of foreigners. East part of Nepal and lately discovered tribes have been an example.

Presently, all the trade routes to India are closed. The people are in great difficulty. The economic situation of the country has been seriously affected. Nepalese people are struggling for two separate treaties ie. transit treaty and trade treaty on the basis of present context not on the basis of 1950's treaty.

Nepal government claims that the country is respecting human rights. She has celebrated her silver jubilee and even reproduced a colourful picture depicting human rights. Yet there are a number of christians in prison.

I still feel that the time has come that churches will have to be involved in the services which are untouched by others.

Submitted by
NARAYAN MAHAJAN

V
CHRISTIAN WORK AT VENGURLA (INDIA)

According to the message of the Gospel although the poor are granted privileges, there remain some unfortunate people who must be helped. They are the needy persons whom we must assist.

No other text makes this so clear and emphatic as the Illustrative Passage in Mathew 25: 31-46.

Out of nearly 59 small and large medical instituions in the area of the Church of North India we are just one of these institutions that continue to do Christian work through St. Luke's Hospital Vengurla.

This is a very old institution started by Dr. R.H.H. Goheen in the year 1912 as a small dispensary. It gradually grew into 150 bedded hospital with many of the necessary facilities.

Amongst all the talukas in this district Vengurla proper is a very backward area. The Government of Maharashtra has declared this part as an economically backward area. Practically all the male population goes out of taluka hunting for jobs to keep the women folk and children at home. The women to children are not properly cared for and they depend entirely on the views and whims of the head of the family. They own land in small pieces which is not fertile. Few persons have monopoly of mango and cashew crop. The ladies and remaining men folks work to earn their living. Out of 88% of rural people 55% of the people are under poverty line. So the hospital has to do a lot of charity work for the people in the poverty stricken area. Because of lack of funds and personnel only one doctor has been taking full load of the hospital for more than 10 years. Now we have one more doctor.

In every field of this hospital today there is much talk about change. The suggestions came in pouring for a need to change so we now face and experience another burden to our heavy situation making our lot very difficult and almost intolerable. It must be admitted that we have to accept change without saying anything or thinking any more. So that we gladly accept this change and take recourse to lessen the burden of those who are already burdened with poverty. We believe that this is our christian calling. Also it is our responsibility to reach the needy, the poor, orphans and the sick in as much as we are members of the church.

Out of 88%, 55% of people are not only under poverty line but also are away from the latest knowledge of health, education, nutrition and development. So many other inter related aspects such as maldistribution of resource, illiteracy, ignorance and social injustice are experienced in a vicious circle.

To reach the goal in the area of health for all by 2000 AD we need every christian to work hard to share the burden of our community and the people who continue to receive scant consideration even after receiving Independence.

Though now many private clinics and primary health centres are active all over St. Luke's Hospital remains still the only hospital that could serve not only Vengurla proper but the people all over the district. The fact remains that we do not have any other good health centre round about 90 miles of Vengurla. So in a way we have no alternative left but to cater for curative work.

As we worked we realised that for a full health programme and improvement the following points are important.

1. People's participation is the essential thing and
2. Health is primarily a personal responsibility.

So we worked hard to make the people realise that the active participation is a must and health remains with them as their own property. We could get along this line very smoothly and we are now able to handle other necessary and related matters simultaneously and thus our coordinated and integrated community oriented health and development plan is being worked out at St. Luke's Hospital. Sometimes due to lack of funds personnel and equipment we have to move very slowly but steadily. This is the way we are marching and stepping forward since Aug. 1984.

We started with one villge of 3000 population 13 miles away from St. Luke's Hospital. We have now covered the whole Taluka - Vengurla of 28 villages.

We train:-

1. Village health workers 1 per 1000 heads
2. Multi purpose health workers (Aux. Nurse Midwives) 15 per year with the affiliation of the Maharashtra Nursing Council. Our trained ANMS are placed in each village. They work as village health personnel.

We have clinical instructors for village health workers and supervisors too. They are paid very little amount as salary.

We consider few sectors such as :

1. Maternal and child health - This includes ANC, Intranatal, PNC, immunization, breast feeding and constant advice to mothers.

2. Safe drinking water. This is inclusive of oral rehydration, education on water purification, chlorination of the wells, disposal of the used water by making soak pit and kitchen garden, repairing and cleaning of the wells.
3. Female literacy - I am very proud to say that my 14 village health workers are conducting adult literacy programmes. From 1st of Oct. 1989 our 4 health workers are elected as NFE motivators. 3 health workers are conducting Montessori classes.
4. Nutrition Education - We cooperate and participate in schools, mahilamandals, (Women's clubs) M.C.H. programmes.
5. Environmental sanitation - We encourage people to build pit latrines and smokeless chullas, gobar gas plants and keep the environment clean. We promote garbage pits and also personal and community hygiene.
6. Under fostership programme we have 50 children in a boarding under our care and supervision.
7. Take care of minor health problems such as first aid, communicable disease care and control; also health education on these topics is given to ladies.
8. We take camps on

   Liquor prohibition
   Stop early marriages
   Sex education
   Dowry deaths
   Nutrition education and health education.
9. We take active part in UNICEF camps, Govt. oral training camps, N.C.C. Camps of schools and colleges.
10. We form mahila mandals, we are taking part in all social activities. We have formed one federation called youth forum. All mahila mandals and youth groups are members of this federation; by our active participation we are able to give concrete expression to the needs felt. Thus after discovering the reality, we as youth forum act on it. While discussing such needs the members get motivated to think of down trodden people and find out the way to help them.

Last but not least is the fact that we are in 2nd year of women's health and development project.

In the 1st year in 1988 total 80 candidates were trained for tailoring and craft.

In follow up we found that most of them are earning their living. Four candidates have started their own small tailoring casses.

Our tailoring school is registered with the Government now and is a permanent support for St. Luke's Hospital Vengurla. Now in 2nd year of project we have started another tailoring class 13 miles away from Vengurla at Ansur Pal which will be at the service of 3 to 4 villages. 7931 population could be served.

In the same village few ladies received loans for basket making. Tailoring and craft students, mahila mandal ladies and the ladies who received loans and other beneficiaries will be able to gather in this class room and we will have place for clinic as well as village development in future.

This class is not well equipped yet. When we will make it well equipped. We would like to register it and make a permanent place from where we will be able to work for the health and development of the population there.

Vengurla is situated on the sea shore, in a very beautiful place with a clean beach. On behalf of the christian community I welcome you to come and visit us.

Thank you,

MRS. K. SEELAM

VI
WELCOME ADDRESS

Rev. Azariah, the moderator of the development and service desk of Christian Conference of Asia, the honourable commission members of Christian Medical Commission of World Council of Churches, Dr. Sang Jung Park the General Secretary of CCA, officers from CCT, honourable delegates from different churches, ladies and gentlemen:

It is a great pleasure and privilege for me this morning to welcome you all on behalf of the members of the Presidium and the General Secretariat of Christian Conference of Asia. In my opinion, it is a new era in the history of CCA that such a Consultation under the banner of Christian Conference of Asia in cooperation with CMC-WCC is being held from today till 17th of this month.

I am extermely greatful to the Executive Secretary Dr. Kenichi Otsu, and the Development and Service Desk of CCA that he has taken so much pain to organise this Consultation and also tried to put some historical background with facts on the involvement of CCA in health and healing ministry over the years. In 1957 EACC first meeting in Hong Kong and in 1967 a second meeting in Gotemba, Japan played a significant role in the history of christian commitment by bringing together many aspirations of Christian Health Workers for a common understanding in the healing ministry of the Church. Unfortunately since 1967 there has been no further meeting of Christian Health Workers for the whole continent of Asia. In Singapore 1973 EACC took a new name and shape as CCA and since then till 1985, the Health Concern Committee was a program under the Development and Service Desk of CCA. Dr. Kenichi Otsu has produced for you the historical background. To review the Health Programme within CCA, Dr. Daleep Mukarji, the General Secretary of CMAI, Rev. Azariah, Dr. Sang Jung Park and Dr. K. Otsu took much trouble to coordinate this issue and I am grateful to each of them.

Historically, the Churches in Asia have been involved in health care delivery systems through the Institutions, and more recently, through community oriented Primary Health Care programmes. I am very much encouraged and enthusiastic with the theme of the Consultation. In this Consultation we will have to think why the Churches should be involved in the Ministry of Health, Healing and Wholeness ? Asian Churches must review the present involvement of the Churches in health and social justice. Since 1973 to 1985 CCA has not done much to promote this health programme of the Asian Churches; neither has CMC-WCC taken much care to promote the health delivery system of the Asian Churches.

Still in many countries of Asia, like Bangladesh, Nepal, India and Pakistan, poverty is rampant. Millions of children are dying because of malnutrition, water borne diseases etc due to

ignorance, lack of education and sanitation. People are not aware of safe drinking water. On the other hand, highly qualified christian young doctors are running after operating microscopes and laser surgery.

I strongly believe today that there is a challenge in front of us to improve the health programmes of Asian Churches and that South relations and mutual understanding will have to grow more and more. The resources in Asia must be properly utilised to improve the quality of the health programmes in our Churches. Many Christian Organisations exist in Asia who are concerned with health programmes but we do not have a platform to coordinate with each other and try to understand each others programmes. Sometimes, it is a competition between organisations. CMC or CCA must play a vital role to work together and bring these organisations closer so that Churches health programmes may be benefitted through this process.

It is a unique situation and opportunity for us today. The responsibility which was given to us as Church workers, to show His love through unity, integrity and solidarity, can be expressed through this Consultation.

I believe that this Consultation will bring all Asian participants together who represent the Churches and those involved in innovative health programmes to share their experience and to rediscover and redefine the churches mission in this area with a new strategy involving the people and making a new society for the Asian Churches.

I do hope and pray that this Consultation will bring some fruits for the Churches in the ministry of healing.

DR. S.M. CHOWDHURY
Member-Presidium, CCA

Dated : 13th Nov. 1989
YMCA, BANGKOK

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VII
HEALTH CONCERNS OF CCA

I. **December, 1958 Hong Kong**
"The Christian in Medical Work in East Asia Today"
a year after the formation of the EACC

II. **1972 Bangkok**
"The Role of Health in the Development of Nation"
held by EACC and the Asian Federation of Catholic Medical Associations
First Asian Ecumenical Conference
Main Points
1) Recognition of inadequacy of the existing patterns of health care, based on large medical institutions.
2) To improve the health of rural community.

III. **1973 The CCA Assembly (Singapore)**
Appointment of a health consultant and a full time technical consultant:
Dr Noboru Iwanmura (1975-77)
Ms Susan Rifkin (1973-77)
They visited various church-related and other organizations.
They made guidelines for CCA health concerns.
Guidelines
1) To stimulate local communities to develop responsibility for their own primary health care;
2) To integrate community health into community-based action as a component of integrated programming;
3) To base community health action on analysis of the social structures operating in or upon the community;
4) To support research into the use of local technologies and traditional herbal medicines;
5) To bring together in workshop approaches, people engaged in rural community health motivation and organisation, to maximize the concerted efforts and skills of community organisers and medical personnel at all levels.

From these guidelines, it was necessary to make possible a dialogue between health professionals, planners, social scientists, community organisers and village level health workers.

IV. For enabling the above dialogue, two workshops were organised

1) November, 1976 in Philippines
   "Workshop on Rural Community Health"
   Participants: Philippines, Indonesia and Sarawak
2) March, 1977 in India
   Participants: India, Nepal

Main Points

1) To consider health from other social aspects.
2) Emphasis of community participation.
3) Fixing the role and function of the medical professional, the CO and village health worker.
4) Suggestion of training programmes for village health workers.
5) Financial support for the programmes.

Recommendations

1) To discuss local situation rather than national or sub-regional
2) To establish resource center
3) Producing a handbook on rural community health
4) Church related community health programmes - less institutionalised and more flexible

CCA Assembly, Penang 1977

V. 1979 Tagaytay City, Phillippines

"Community Health Training Workshop"
held by CCA and National Ecumenical Health Concerns Committee of NCCP

Participants: health workers, grassroots CHWs, c.o., social scientists and health professionals, 6 countries

Main Points

1) To view health from the point of social structure
   The Asian health system is just a point of the whole system and it relates to economic, political and cultural problems of Asian societies.
2) Emphasis on community health and peoples' participation.

Recommendations

1) Biblical/spiritual reflection for understanding socio-economic, political and cultural problems.

2) Priority for health is on the poor and oppressed.
3) To appoint an Asian health Co-ordinator

VI. 1981 Bangalore Assembly

Recommendations from CCA General Committee

Forming a Task force:

1) To select a project staff for Health Concerns
2) To prepare "A Rural Health Workers' Workshop" in 1982

VII. May, 1982 Nagoya, Japan

The task force appointed Dr. V Benjamin (1982 - 1984) as a project staff.

His tasks:

1) To organise rural Health Workers' Workshop in 1982
2) If possible, to organise second one in 1983

VIII. October, 1982 Vellore, S. India

"Community Health and Development Workshop" in South Asia

Participants: Sri Lanka, Bangladesh, Nepal, India

* For rural health workers

Main Points

1) Continuation of the Tagaytay Workshop in 1979.
2) Focus on peoples' participation in comprehensive development programmes
3) Health is an inseparable component of the total development process, therefore, holistic approach to development has to be taken up.
4) Organizers should avoid being "directors of programmes".
5) God's mission is to release people from various kinds of bondages such as disease, poverty, exploitation and suffering
6) Preventive care rather than curative.

IX. May, 1983 Tomohon, Indonesia

"Community Health Workshop" in Southeast Asia

Participants: Indonesia, Thailand, Malaysia, Philippines, Holland (Observer)

* Training of health workers

Main Points

1) Health would be a dynamic state of physical, mental, social and *spiritual* integration.
2) Healing should be considered toward the whole person in community.

X). 1984 -

"It is hoped that the important aspect of development will function together with a network of health workers and institutions in the CCA region and that it will continue to be a valid concern within the CCA programme structure". (From Bangalore to Seoul, 1985)

"Collaboration with CMC/WCC, ACHAN and other organizations which have common concern in the region is envisaged" (Programme Committee, Hua Hin 1986)

Rev. K. Otsu
CCA

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I
HEALING AND WHOLENESS FOR THE POOR

Health, Healing and Wholeness was the subject of a special session at the World Council of Churches Central Committee meeting in Moscow in July. The following paper was presented to the committee during that session by Ms Hari M John, MD.

TWO decades of life in an impoverished rural community originally as a health professional but later free of this limiting "category", brought me into contact with all the complex dimensions that the terms health, healing and wholeness signify for such a community.

In fact, it taught me the organic and integral relationship that these terms had in the context of a marginalised existence. Starting from the issue of health, I came across the need, first and foremost, for an all-round healing of entire communities - those of low-birth, the tribals, the women, the landless - who have been wounded, wounded economically and socially, wounded in their psyche.

The healing methods that we have to offer, cater in a small and superficial manner, to the mere physical part of their misery. Their vast unmet basic needs of food and water, of land and wages, of education and housing, which create diseases of poverty, are traditionally and often deliberately ignored.

Therefore, the first lesson I learned was that health derives from justice and that orthodox and "medicalised" solutions like health delivery systems, doctors, nurses, medicines, and hospitals are marginal to the health of the poor.

One of the most powerful lessons we have come away with, from the years of trial and error, is that the just and fundamental step towards health and wholeness is the healing of the spirit. This was borne out specially in our work with women, who for decades had been oppressed, voiceless, beaten, subjected, patronised, told that they were stupid and ignorant, and reduced to being mere receivers of charity.

Building up the sense of self-worth in this community of women was a long and hard process but this action was the single most crucial key to restoring the community to a semblance

of wholeness and the beginnings of "health", leading to empowerment.

The "class basis" of ill health has been well recognised. What is surprising is the "class basis" of solutions that have been often imposed on the poor even by the Church. It is our contention that this has been done deliberately - because it is a question of power. Hospitals are power, medical colleges are power, professional excellence is power, knowledge is power, mystification is power. But the poor are powerless.

While professing great concern for the poor and in acts of condescension starting some out-reach programs "for" them, by and large, we, as the Church, have limited our understanding of healing to mere physical healing. We have limited our understanding of health to provision of medical services and, immersed in these details, have lost sight of the "wholeness" that is our ultimate objective. We have "medicalised" our solutions and abdicated our healing role to professionals.

Most of these professionals have shown themselves to be arrogant, not in tune with the aspirations of the poor, allocating for themselves well-paid roles, with no humility in them to recognise that even the poorest have experiential knowledge which can form the foundation of their liberation.

The results of this act are plain to see. The health status of the poor shows only a marginal improvement over the last four decades. Infant mortality and maternal mortality remain inhumanly high. Diseases of poverty like simple diarrhoea, childhood illnesses that are easily prevented and contained with simple and effective techniques like health education, have become killers.

Millions of children die of malnutrition or become blind due to lack of vitamin "A". All this in the midst of plenty, among centres of excellence that our mission hospitals and medical schools are, among the hundreds and thousands of professionals that we have trained in the past decades and with the vast amounts of "Christian" money that we have allocated for so-called health care.

Something is obviously wrong. We have named the name of the Christ but have not cared for the poor. We have tinkered with and perpetuated systems — institutions, professionals, high tech diagnostics, expensive drugs — that have not worked in the past and will not work in the future while deliberately shutting

our eyes to the fact that only a structural change in our society brought about by empowering the powerless, can bring justice to the poor now, not beyond the grave.

We have failed to demonstrate solidarity with the struggles of the poor and have been a conscious part of their oppressors.

At the turn of the century, the poor of the world have a dream - a dream of a just, participatory, pluralistic and sustainable society, a society where people can live in "health" and dignity. With us, without or even in spite of us, the poor are destined to achieve this.

What is going to be the role of the Church?

II
A STATEMENT ON THE HEALING MINISTRY

THE ABUNDANT LIFE, promised and proclaimed by Jesus Christ is a new quality of life, the source of which is He himself, and it is a free gift of God in Him. The outward working of this life is health, healing and wholeness. Health in this sense is comprehensive, of the total person-physical, mental and spiritual and social, making one whole, and not merely the absence of disease. It extends further in restoring relationships between God and Man, between man and man, man within himself, and between man and the whole creation. This divine purpose for individuals and communities is the ministry of healing, or of reconciliation. Such a wider and deeper understanding of healing, health and wholeness is vital to the mission of the Church in India. Therefore, we in Christian Medical Association of India affirm the following:

1. Preaching, teaching and healing together comprise the total mission of the Church.
2. Healing, Health and Wholeness is God's intention for individuals, society, and for the whole creation.
3. Healing Ministry of the Church, therefore, announces God's work of SALVATION in Jesus Christ, bringing wholeness and justice to the World.
4. The local congregation has a central role in the Church's healing ministry.

5. In the Church's mission there is a preference and focus on the poor, the oppressed, and the most afflicted and the marginalised in society.
6. All healing is from God. In the healing ministry of the Church, Jesus Christ, in and through a congregation, institution or health professional; is always the healer.

We believe that the biblical faith call us, indeed, commands us to a mission to proclaim the gospel and to heal the sick. The healing ministry is an integral component of the mission of the Church in India and elsewhere. Christian Medical Association of India - the health arm of Protestant and Orthodox Churches in India - seeks to assist and support the Church to rediscover and rededicate itself to this mission. It challenges the Church to this wider understanding of health, healing and wholeness, and to go beyond community health to healthy communities. CMAI endeavours to participate in the mission of the Lord, Jesus Christ, the Great Healer.

III
MISSION ON STATEMENT ON THE HEALING MINISTRY (1987)

The United Church of Christ in the Philippines engages itself in wholistic health ministry in obedience to the will of our Lord Jesus Christ for abundant life for all.

In affirmation of this conviction, we thus further state that health is a basic human right.

While it is the duty of the State to provide health care, the church has a moral responsibility towards the attainment of wholesome and healthy life for everyone as God intended, recognizing that the art and science of healing is an integral part of the message of salvation.

The active participation of the people of God through her various institutions shall enable the Church to fulfill her healing ministry.

Though the Church focuses her attention upon people, she cannot close her eyes to the ills of society which give rise to

poverty of body and spirit. It is therefore, necessary for the Church to address herself to the historic problems of domination, unequal distribution of land, inequality in economic opportunities and resources, and oppression and exploitation of less privileged and marginalised Filipinos.

Ref: E.C. August 20-27, 1987

IV
HEALTH, HEALING AND WHOLENESS
An Enquiry into Christian Perspectives

The Christian Medical Commission has been engaged for the past twelve years in a study on health and healing from the Christian perspective. This document describes the background, objectives, and methodology of the study and then presents a synthesis of the findings.

Background

The Nairobi (1975) mandate to the Christian Medical Commission (CMC) called on the sub-unit to "serve as an enabling organization to churches everywhere as they search for an understanding of health and healing which is distinctive to the Christian faith."

This was to be done by "exploring insights into, and promoting theological reflection on, the Christian understanding of life, death, suffering and health, that these may find expression in the church's concern for health care as a healing community," and by being "alert to the widening dimensions of healing which transcend the concern with physical pathology and assess the input of spiritual, social, ethical and psychiatric insights."

In response to this mandate, the Christian Medical Commission embarked on a study on Health, Healing and Wholeness in 1978.

What has been done

Rather than make the exploration a centrally located academic exercise, CMC took the study to the grassroots. Over the next ten years, a dozen consultations were held on six continents, the Caribbean and the Pacific. They brought together pastors, theologians, and medical professionals to discuss for a week their understanding of the Christian perspective on health,

and to sketch together an outline of the churches' role in health.

Then an advisory committee was formed to oversee the documentation of the study findings and develop ideas on how to use them. A volume bringing together some of the historical documents and seminal papers of the study is being published.

Executive summary of the study findings

The major theme brought out in the consultations is the fact that *health is not primarily medical.* Although the so-called "health industry" is producing and using increasingly sophisticated and expensive technology, the current reality is that the majority of health problems in the world cannot be addressed in this way. The churches are called to recognize that the causes of disease in the world are socio-economic and spiritual as well as bio-medical.

Justice and peace

An important reality of today is the fact that the number one cause of disease in the world is poverty, the end result of oppression, exploitation and war. Providing immunizations, medicines, and even health education by standard methods will not significantly ameliorate illness due to poverty. The churches are called on to see this as a justice issue to be raised in the centres of power, local, national, regional and global.

The prophets cried out against the oppression and exploitation of the poor in their day. Jesus began his ministry by quoting Isaiah's prophesy of liberation for the captives and freedom for the oppressed, sight for the blind, and good news for the poor. Many study participants shared stories of their efforts to accompany the poor and the outcast in their struggle, proclaiming and demonstrating that there is healing in working for the liberation of the poor.

In serving the poor we also discover that they have much to share. Christians in struggle for justice and human rights around the world have gained new insights into the healing power of God and have learned to overcome despair and fear of death through trusting Him.

Deaths due to armed conflicts and other forms of political violence have continued to be a reality of health in the eighties. For thousands in the world, state terrorism through "low intensity conflict", torture, imprisonment and other forms of human rights violations have made wholeness an impossibility.

The churches themselves have often demonstrated a top-down paternalism in their provision of health care services, inhibiting the development of community resources and achievement of self-reliance. The resulting dependency on outside resources for health has ultimately served the rich and powerful rather than the poor. Many examples emerged through the consultations of programmes which had found ways to empower communities, through participatory learning experiences, to eliminate the major causes of illness and death in their midst.

Integrity of Creation

Another significant proportion of illness in the world is self-inflicted. What we do to ourselves individually and collectively out of ignorance, greed or simply lack of self-contol causes physical, mental, spiritual and ecological damage which is not best addressed by medical technology.

In industrialized countries over 80% of illness and death is reported to be due to destructive lifestyle and the problem is growing rapidly as a result of "modernization" throughout the world. Development of heart disease, hypertension and diabetes has accompanied industrial development in many countries as new diets and attitudes towards manual labour are introduced and addicting drugs such as alcohol and nicotine are promoted.

As nations large and small engage in struggle for military and technological supremacy, nuclear wastes proliferate to endanger the health of the whole planet. As materialism replaces community as a cherished value, increasing pollution threatens the life of humans, other animals, and all living things.

Churches are called on to advocate and practice the integrity of creation, beginning with the human body, as an integral part of the gospel.

The Spiritual Dimension

Most important to health is the spiritual dimension. Even in the midst of poverty some people stay well, while among the world's affluent many are chronically ill. Why? Medical science is beginning to affirm the Biblical truth that one's beliefs and feelings are the ultimate tools and powers for healing. Unresolved guilt, anger and resentment, and meaninglessness are found to be the greatest suppressors of the body's powerful, health-controlling immune system, while loving relationships in

community are among its strongest augmenters. Those in loving harmony with God and neighbour not only survive tragedy or suffering best, but grow stronger in the process.

Life is God's gift - when we choose the spiritual dimension of life we opt for the abundant life which is wholeness. As persons come to trust in God's unconditional love thy are freed to love each other and come together, freely confessing and forgiving, in healing community. Churches have too often made confession a mandatory exercise for the purpose of condemnation, and used brokenness an excuse for exclusion for the Christian community. The unity of Christians, whether local or global, can only be created and nurtured through a willingness to risk self-emptying, confession, listening and caring.

Traditional societies have a wholistic understanding of health which understands beliefs and feeling to be crucial. Much can be learned from a dialogue between traditional healers and western medical practitioners.

Not only does the Christian Gospel speak directly to the spiritual reality of health, but the understanding that God's intervention in history through Christ brings healing. Salvation is the very core of the good news. In the first consultation of the series Dr. Emilio Castro pointed out that "the healing ministry pertains to the whole being of the church."

I. INTRODUCTION

Background of the Study/Enquiry

The Christian Medical Commission, a sub-unit of the Unit on Justice and Service of the World Council of Churches, was directed by the Central Committee in 1976 "to set up and develop a means for sustained enquiry, description and reflection concerning the connections between health, being human, the community and the Kingdom of God." The CMC embarked on this path after the completion of its first mandate—a period of 8 years—during which great emphasis was laid on redressing the imbalance of institutional medical care through promotion of primary health care.

Growing dissatisfaction with what one pastor called the 'garage mechanic' approach in modern medicine made Christian groups in many countries begin to search for what we now call 'wholistic medicine'. Independent workshops and consultations

were held in different parts of the world. Sometimes they were sponsored by the CMC or by other units and sub-units of the WCC.

The CMC study/enquiry owes much to the insights drawn from two consultations organized jointly by the World Council of Churches and the Lutheran World Federation; first in 1964 focusing on medical missions in the Third World, and then in 1968 on the role of the church in healing. There was a growing concensus that health care is not the prerogative of a few professionals but is a part of the witness of all Christians. It was this new realization that gave impetus to the study/enquiry into the role of the church in health.

Objectives of the Study/Enquiry

The purpose of the study/enquiry was to learn about:

a) new thinking on the churches' involvement in healing, both of a theological and practical nature;
b) healing practices and attitudes within traditional societies in developing countries;
c) ways by which local communities care for and support their sick and suffering members; and
d) theological reflection on the Christian understanding of health, healing, wholeness, life, death and suffering, and human values.

Methodology of the Study/Enquiry

Regional Consultations

Rather than to make the study/enquiry an academic exercise centred in Geneva, the CMC went to the people. A network of multi-disciplinary resource persons in different countries of the world was built up. CMC began gathering information by sending questionnaires to a wide range of individuals and organizations. The answers provided the nucleus for discussions in regional consultations.

Ten regional consultations were held around the theme "Health, Healing and Wholeness" as follows:

1.	Caribbean	Port of Spain, Trinidad	March 1979
2.	Central America	Omoa, Honduras	March 1979
3.	Africa	Gaborone, Botswana	October 1979
4.	Southern Asia	New Delhi, India	August 1980
5.	South-East Asia	Denpasar, Bali, Indonesia	April/May 1981
6.	Pacific	Madang, Papua New Guinea	September/ October 1981

7. South America	Quito, Ecuador	June 1982
8. North America	Chevy Chase, MD, U.S.A.	December 1984
9. European	Budapest, Hungary	September 1986
10. North-East Asia	Kyoto, Japan	April 1987

An Egyptian National Seminar on the Christian Understanding of Health, Healing and Wholeness was held in Alexandria, Egypt, from 1-4 May 1980. The seminar was originally intended to lay the groundwork for a Middle East regional meeting, to be co-sponsored by the Middle East Council of Churches and the CMC. However, due to the political situation and the difficulty of getting representation from various countries, it was not possible to hold the regional meeting.

The regional consultations brought together 650 people from various disciplines and involvement. They shared views and activities on health and development emerging from local communities. As the consultations moved from one region to another, new issues emerged. For example, in Central America, the issue of structural injustice and its effect on health was highlighted. In Africa, the issue of traditional healing and African spirituality were central to the discussion of health, healing and wholeness. In Europe, community building was added an important concern.

Presentation to the 1981 Central Committee Meeting

A report on the first half of the study/enquiry was presented to the Central Committee in Dresden, German Democratic Republic, 16-26 August 1981. The basic messages presented were:

— The issues and concerns related to health and wholeness are those related to justice, peace and full human development.
— The possibility of improving health will only be realized once we are more aware of our personal responsibility for health.
— Church-related services are challenged to develop a new style of authentic people's participation which has its base in the community, addresses their own concerns, and promotes their own dignity.
— The church is called in obedience to the Gospel to engage actively and ceaselessly in a healing ministry which will truly promote the healing of the peoples and the nations

and restore Christ-given wholeness.

(1981 Central Committee Minutes, pp. 31-32)

The Central Committee in Dresden decided that:

1. Its members as well as member churches be urged to help interpret, influence, initiate and support activities which will promote health, healing and wholeness in their communities and nations.
2. Its members as well as member churches be urged to support and encourage the continuation of the reflection and study of the churches in the area of health, healing and wholeness, to discover renewal in the healing mission and ministry of the congregation, and to share with others and with CMC the insights of those engaged in healing service.
3. Its members be urged to help CMC enlarge its network by recommending persons, groups and organizations whose experiences can be shared.
4. Member churches be urged to appreciate more fully the healing imperative in reaffirming and supporting those persons and groups working to combat poverty and injustice and in promoting their dignity.
5. WCC units and sub-units remain alert to concerns and issues of the CMC which relate to their own concerns, continue to be open to CMC initiatives, and collaborate in programmes, contacts and visitation."

(1981 Central Committee minutes, p. 73)

Vancouver Assembly 1983

The healing ministry of the church was discussed during the Sixth Assembly of the World Council of Churches under Issue Group No. 4, Healing and Sharing Life in Community. In the Issue Group meeting it was affirmed that the church's sharing and healing ministry originates from the very life and mission of Christ Himself. It demands right and direct relationships based on love and justice, with self, with neighbour and with God.

The Churches were challenged to:

— carry out their healing ministry in a wholistic way;
— play their role in bringing about change both locally and abroad, in health policies and programmes;
— emphasize and explore primary health care and the humanization of existing institutional services;

— study traditional healing practices;
— study the role of spiritual healing;
— develop people who are well-trained and motivated in doing health care;
— give priority to the rural and urban poor and the populations most at risk in the provision of health care;
— emphasize community and individual participation in health;
— view medical technological advances in their proper perspective;
— face responsibility the problems that enslave many people, like alcoholism and drug abuse; and
— give meaningful participation and attention to the disabled and aging.

The Issue Group suggested to the Programme Guidelines Committee the addition of new themes in the study on the Christian Understanding of Health, Healing and Wholeness. The new issues to be added to subsequent studies were:

— sickness, suffering and dying;
— wholeness as it relates to aging persons and those with disabilities;
— strengthening of efforts to enable churches in the renewal of their congregational life to fulfill a more caring and healing ministry.

After the last of the regional meetings, an Advisory Group on Health, Healing and Wholeness was formed from among the CMC commissioners to do a 'critical analysis' of the study and suggest meaningful ways to present the final report to the Central Committee and to the WCC constituencies. Emphasis was given on the need to popularize the results of the study within local congregations.

The Advisory Group authorized the preparation of this report for presentation at the CMC Commission meeting in Brazil in May 1989.

Following is a synthesis of the theological reflections, realities, stories, issues and challenges emerging from the study.

II. THEOLOGICAL REFLECTIONS

Being Rooted in the Triune God

The healing ministry pertains to the whole being of the church. The whole being of the church finds its roots in the

Triune God revealed to us as the living Creator God, made flesh in Jesus Christ and received as the liberating power of the Holy Spirit. It is in abiding with the Triune God, similar to the image of the branch remaining in the vine (John 15:5), that the whole being of the creation of God finds health, healing and wholeness.

Life is God's Gift

God's gift to people is life—life in all its fullness (John 10:10). It is important to understand this, because the first sign of the Kingdom of God is life.

In the story of creation, God formed the human being out of the dust of the ground and breathed into the nostrils the breath (*ruah*) of life. The human being became a living *nephesh*. The important feature of the creation anthropology is that *nephesh* is not a part of the human being, but is the whole human being.

As sojourners in the whole mystery of creation, human beings face the choice between life and death. God's plan is that human beings and all of creation may have life that is good and abundant. This means right relationship with oneself, with the human community, with the rest of creation and with God. This means caring for creation, which sustains life, and nurturing our relationship with our fellow human beings and with God. This is why God urges human beings to choose life.

In choosing life, we also choose health. Health is a dynamic state of well-being of the individual and society; of physical, mental, spiritual, economic, political and social well-being; of being in harmony with each other, with the material environment and with God. Well-being refers to our dynamic contact with the Source of out Being, and as Christians, we believe that it is Jesus Christ that gives us life.

Jesus Christ's example and teaching point us to the way of life based on the norm of the Gospel. In his healing ministry, he emphasized the importance of relating healing to the life of the community. He questioned existing laws, cultural values and practices that did not serve the interest of the poor.

After affirming that the paralytic man, waiting for the stirring of the pool at Bethsaida, really wished to be healed, Jesus told him to "Rise up, take up your mat and walk" rather than to wait for the commonly believed phenomenon of the "whirling of the pool".

To the "unclean" woman who, despite the prohibition against touching a man, reached out and touched the hem of His garment, Jesus said: "Daughter, your faith has made you whole."

Jesus healed not only physical infirmity but freed people from their guilt. Much to the anger of the Pharisees He forgave people of their sin, reminding them not to continue in sin or much worse than sickness can happen. Never discovering life is worse than death, never having lived is more catastrophic than dying.

Being in a dynamic relationship with Jesus means living up to the demands of the Gospel. Being rooted in Jesus enables people to discover the meaning and purpose of life. Jesus' concept of health, healing and wholeness is to set people free from all that stands in the way of life. But first He invites us to carry His yoke, to be burden-bearers, witnessing to and working for the Kingdom of God.

In the process of living out the demands of the Gospel, temptations come and there are times that we deviate from the paths of righteousness. But the invitation to life is open to all who acknowledge and confess their sins and ask for the restoration of relationships. Life can only be restored in the context of our relationship with the community. This is why Jesus admonished us to restore our relationship with a brother or sister whom we have wronged before giving our offering.

Resources for Healing

Health in the Hands of the People

Disharmony in relationships lead to alienation, separation, brokenness, and sin—a lack of well-being. Traditional concepts of health and sickness support this view. In some cultures, e.g. in Africa and Asia, animal sacrifice and other forms of offering are given to appease the wronged spirits of nature and ancestors. The family or a community mediator such as a village elder deal with broken relationships.

The church can learn from these traditional models of caring communities in different cultures and religions. Many congregations have not developed mechanisms to care for their members. So, just like the lunatic man of Gadara, the response is to get rid of the problem by excommunicating or isolating the person instead of coming to his/her rescue and restoring his/her life in community. In recent years AIDS patients have added

to the long lists of persons who need the care of congregations. Studies from all regions have revealed how important it is for each member of the congregation to contribute to the healing function of the church.

Our Christian belief is that Jesus Christ's sacrifice in the crucifixion event took the place of animal sacrifice. St Paul called on the followers of Christ to present their bodies as living sacrifice by not being conformed to worldly values, but by being transformed. He gave the promise, "Behold, Jesus Christ makes all things new!" Thus we are liberated and saved through Christ.

Our body/mind/spirit (*nephesh*) can be broken by social injustice, misuse of power, unhealthy relationships and life style, lack of care and abuse of creation, individualism, materialism and false spirituality. Many people needlessly suffer. At times it seems that some people are born without any choice but to suffer. But our encounter with Jesus Christ, the Healer, reminds us that the meaning and purpose of life is found in our ongoing, dynamic, continual, and liberating struggle with the powers that deny God's gift of life. This is a message for both the rich and the poor.

Primary health care and organized people's movements for human rights and liberation are practical ways by which we can be involved to fight the powers that deny God's gift of life. Education for critical consciousness, discovered by reading the Bible with new eyes, is a basic element of people's movements. It includes social and historical analysis and leads to solidarity with the poor, deprived and oppressed, entering into their own experiences and world view. We are thereby enabled to join with them in seeking the signs of the Kingdom while living the demands of the Gospel. These healing communities can share ideas and models with each other for their mutual development with the ultimate goal of being awakened—of finally being able to see the light and hear the cries of the people of God.

Healing Practices

Among the practices which can aid in healing are modern medicine, traditional medicine, other forms of medicine, prayer and liturgy. Each, especially when coupled with faith, can provide healing. Each can also be used for evil when the purpose is to exploit or harm the individual or to use limited resources for treatment of a few while robbing others of basic health care.

Modern Medical Science and Technology

Medical science and technology are a reality in today's world but they must be viewed from the proper perspective. In the light of the Gospel some serious conflicts arise:

— these advances have widened the gap between the rich and the poor. Even church-related hospitals, equipped with modern technology such as computerized axial tomography, are only able to serve those who can afford to pay for such examinations.

— specialization not only fragments health care in opposition to the total person socio-theological perspective, but also makes its costs beyond the means of the poor.

Medical research is best done with the view to serve the entire human community and therefore must be in close dialogue with the people, listening to their viewpoints and considering their ethical values.

Traditional Healing Practices

People's world view is closely associated with their state of health, their health-determining attitudes and their behaviour, health-seeking and healing practices. In this section we present some traditional world views and healing practices with examples from various regions as they were presented at the regional consultations on Health, Healing and Wholeness.

The Traditional World View:

The traditional societies are usually essentially religious communities. People have consciousness of God as a living Supreme Being who, though remote, beyond the sky, is represented on earth through smaller deities, spirits and ancestors. Disease, health and healing has a fundamental religious dimension. They cannot be divorced from a global vision of the world, particularly of the totality of a person's life. There is no separation between the sacred and secular. A person's life is a cycle of two parts, two words, two lives: the world of the living; and the world of the dead, the ancestors.

According to this view, the Almighty (God) intends each living being to complete this cycle or cycles without interruption. Any interruption or disturbance (evil spells, illness, infirmity, death before the end of the cycle) is an abnormal phenomenon. The cycle can only be interrupted by those who cast evil spells.

A child is seen as pure and innocent but is vulnerable to 'casters of evil spirits', while the adolescent can be both responsible for his/her own misfortunes and also as a victim of evil spells. From adulthood to old age the law of 'rebound' applies. The good or evil done comes back to its author. Even the adults can fall victim to evil spells.

In many other societies, health and disease is seen in terms of:

- balance of body humours;
- equilibrium of body functions, tranquility of the mind and harmony with the environment;
- pleasant disposition of mind, soul and body;
- harmony in relationship as every being is interrelated and interdependent.

Thus the traditional societies view health as complete harmony within an individual, family, community and environment and may thus be closer to a Christian view of wholeness and harmony than that of Western medicine. Disturbance of this harmony leads to disease, and treatment is the restoration of harmony.

In most of the traditional cultures, healing is part of a socio-religious system in which the power and meaning of life are to be found in the relationships within self, with other people, the physical environment and with the spirits. Treatments, therefore, do not only deal with particular aspects of the sick person's body, but also with the spirits and the social context.

The healing practice normally consits of two components: the medicinal and the ritual. The medicinal component consists of the use of medicinal plants, animals and other inorganic substances. The herbalists prescribe preparations from these which in themselves may have the power to heal or may symbolically link the sick person with that power.

The ritual component may involve divination, trance states, bathing, offering to spirits, participation of family members and even incisions on the body. The ritual practitioner mediates between the people and the spirits and may prescribe certain practices and/or sacrifices that would appease the spirits.

Like Western medicine, it too can be abused. Those in the healing ministry are called to bring every sick member into an encounter with the Creator and with the created beings. Healing which is liberating and translates itself into wholeness is from God.

Prayer and Liturgy - Liturgical Acts that Restore and Promote Healing Communities

In many of the regional consultations, we learned of people who are actively engaged in healing through laying on of hands, prayer, anointing the sick with oil, caring for people by providing food and medicines, visiting the sick at home or in hospitals and hospices. These activities are not to be set in opposition to other instruments through which God also acts to heal the human being. As it was said in the Honduras Consultation, "We cannot exempt ourselves from the responsibility of using the resources of medical science or from political participation simply because we are praying for the sick!" Intercessory prayer creates a spiritual atmosphere that supports health workers. Healing and the building of community according to the Orthodox view are part of the basic concepts of forgiveness and the Eucharist.

The Christian Concept of Community-Building

Called to be 'Wounded Healers'

Our understanding of wholeness is not a static balance of harmony, but building and living in community, with God, with people and with creation. Individualism and injustice are important barriers to community-building and therefore also to health. The members of the early church chose to share their possessions and enter into mutual dependency and accountability.

A healing community does not mean a world without problems, an earthly paradise, but rather striving together to life under God's demanding expectations. Jesus left His family to join the marginalized, the downtrodden and imperfect. Through His willingness to identify, suffer and empty Himself, He gave hope, restored dignity and created community. He led the marginalized back to their own communities, and enabled them to restore their relationships.

A true community is not closed. It cuts across class, status and power structures. Its members must risk moving out to identify with people who are on its fringes, inviting the marginalized and oppressed in, enabling them to rejoin their communities with restored relationships. It is a life-giving organism with movement in and out, steadily giving rise to new organisms of healing and fellowship.

Participation in such a fellowship may be costly. It can involve leaving 'father' or 'mother'; an ongoing process of self-

emptying and an openness to sharing and receiving. There is no true community without giving up something. There is no coming together in community without tears. As parts of a creation which is moaning in pain and longing for its liberation, the Christian community can be a sign of hope, an expression of the Kingdom of God. We are called to be 'wounded healers'.

Community has, by its Nature, a Global Perspective

"One Lord, one faith, one baptism, one God, the Father of all, who is above all and works through all and in all." There is diversity of gifts/ministries, but the Lord is the same; there is diversity of work, but the same God works in all.

As one body, with different parts interdependent, respecting and complementing each other, we cannot have true community unless each of us shares in its life; placing our talents at the service of others. When one suffers, all suffer, when one receives honours all rejoice together. When one part of the body/ community is in pain, the whole body groans. When one part is healed, the whole body is renewed. Something is wrong if parts of the body are feeling well when other parts of the same body are suffering.

Stressing Love of God and Neighbour in our Human Values

The unity of Christians can only be created and nurtured through a willingness to risk self-emptying, confession, listening and caring. The theology of participation may be the theology of emptying and immersion.

To counteract the tendency to individualism, self-centredness and destruction, there must be a deliberate effort to adapt the mind instead to life-giving, life-sharing and community. Doctrinal support for affluence must constantly be challenged. In welfare societies like Sweden, for instance, many young people are saying, "We are looking for love in the midst of all this damned security."

Spirituality as a Faith Resource for Empowerment and Truth

In the church, insights which expand the perception of truth and the reality of God's created world can be welcomed and used.

We can confidently make alliances with forces for truth, whether it is within or outside a Christian context. But we need wisdom to discern where the truth is being distorted and

therefore becomes a force for evil. Not all spirits are of God, and not all energy is the energy of the Creator. The challenge for the church is not so much to warn and withdraw from this arena, but to radically rediscover its own function and power to heal.

Faith and reason must also be brought together in matters affecting illness and health. The mystery of a universe which goes far beyond the limitations of our understanding need not be dismissed.

Spirituality finds expression in relationships, empathy, sharing and involvement. This is demonstrated by the spirituality of Jesus: His communion with God found expression in going *down* from the mountain again, letting Himself be immersed in the people (e.g., the transfiguration and the healing of a boy with an evil spirit). It was an ongoing interaction between meditation, prayer and action. True spirituality is expressed through service and healing relationships with people.

Working for the Liberation of the Poor is Healing

The healing imperatives of abiding in the roots of the Triune God come not only through liturgical acts of confession, Eucharist or rituals like fasting, but also by working for the liberation of the oppressed and caring for the needy and deprived:

> Is not this the kind of fasting I have chosen:
> to loose the chains of injustice and untie the chords of the yoke,
> to set the oppressed free and break every yoke?
> Is it not to share your food with the hungry
> and to provide the poor wanderer with shelter,
> when you see the naked, to clothe him
> and not to turn away from your own flesh and blood?
> Then your light will break forth like the dawn,
> and your healing will quickly appear;
> then your righteousness will go before you,
> and the glory of the Lord will be your rear guard.
> Then you will call, and the Lord will say: "Here am I."
>
> (Isaiah 58: 6-9)

As Christians, we cannot escape the reality of the brokenness and woundedness of the being of the Church, the people of God. This cry came from the people of God as they shared in consultations of their experience in being with the poor, deprived and oppressed. Early in the study the question was asked:

"What is unique about Christian health care?" Now we wonder whether we should rather be asking what *God requires of us as Christians.*

> He has showed you, O man, what is good,
> And what does the Lord require of you?
> To act justly and to love mercy
> and to walk humbly with your God.
>
> (Micah 6:8)

Dr Ian Casson and his wife Ruth are co-medical directors for the health service of the Sioux Lookout Zone in North-Western Ontario, serving 13,000 people living in twenty-eight remote communities scattered over an area the size of France and accessible only by airplane. Living conditions are harsh; medical problems related to poverty, such as tuberculosis and diphtheria, are not uncommon, whereas they are rare in the rest of Canada. In February 1988, five men went on a hunger strike with a view to pressurizing the government into providing better health care for the indigenous people, especially since the government had decided not to rebuild a dilapidated hospital that so far had catered only for them. The indigenous people could not agree to share hospital facilities with other groups since this would inhibit the empowerment of their own people. They abandoned the hunger strike when the government agreed to appoint a panel to review health status and health services in the area. This panel has a year's mandate and is headed by Archbishop Edward Scott, former moderator of the Central Committee of the World Council of Churches, and whom the indigenous people respect.

Accompanying the Poor in their Struggle is Healing

Since love is inclusive, the imperative of being with the poor and accompanying them in their struggle is a Gospel mandate. In identifying with these members of the body of churches, we discovered new insights.

Indeed the maiming of the members of the body of Christ is a reality in our world today. Health workers in Nicaragua, El Salvador, Guatemala and the Philippines have suffered torture, imprisonment and death. Only last January (1989), one of the participants of the South-East Asia consultation, the Rev. Amando Anosa, was brutally murdered by still unknown assassins. Rev. Anosa was active in the human rights movement in the Philippines.

Suffering can be Healing

Suffering is devastating and disconcerting because of its futility, direction and irrationality. It causes unnecessary waste and consumes vital energies to no purpose, both among individuals as well as among communities. To give testimony about a God who is like a loving father or mother, who at the same time allows suffering, is problematic. Suffering is difficult to understand intellectually and even more difficult to deal with emotionally, even for the mature and articulate believer.

The only way for Christians to grapple with the reality of suffering is through the life of Jesus as interpreted in the totality of God's revelation. In Jesus' painful experience we realize the meaning of suffering. We see in the suffering servant the redemptive dimension as a vicarious outpouring of God's love for humanity. The suffering of individuals as well as of communities is part of God's redemptive involvement for the sake of others. As such suffering has meaning in that it has potential healing consequences.

In a group discussion in Kyoto, some participants related examples of how suffering had strengthened character and ultimately led to spiritual growth. They supported the view by pointing out that the ability to feel pain ensures our physical survival in a hostile environment.

Paul's experience of suffering reminds us that we are not without hope, for:

> "We are hard pressed on every side but not crushed; perplexed, but not in despair; persecuted but not abandoned, struck down, but not destroyed." (2 Cor. 4:8)

The puzzle of suffering can only be solved within a perspective of hope. Hope springs from the active participation of the people of God in the healing of the real suffering of God's creatures, here and now. All of God's people are in need of help and capable of giving help. Our hope lies in this kind of reciprocity of giving and receiving, of helping and being helped. Wholeness means that only together—the sick and the healthy—do we form a whole.

Death and Dying

The inevitability of death gives us much to think about in our understanding of health and healing. We can, however, make a distinction between preventable, untimely death and death which is our home-coming forever, the great hour destined

by God. Ethical dilemmas are raised by the ability to prolong the dying process with life support systems which may rob an individual of the comfort of his/her family and a peaceful departure from this life.

In the developing countries, people are still dying from diseases that are already preventable. Christians can lead the way in providing models of a comprehensive approach that can free people from preventable death. Thus prevention becomes a tool for healing.

In well-developed countries, emptiness and loneliness can cause slow death or may drive people to escape from these through drugs and alcohol abuse. The economically poor in these countries are also suffering from the same poverty-related diseases that afflict the developing countries. The church as a healing community has a major responsibility to address these situations, both through service and advocacy for a more just system.

III. THE REALITIES OF TODAY

"We know that the whole creation has been groaning as in the pains of childbirth up to the present time. Not only so, but we ourselves who have the first fruits of the Spirit, groan inwardly as we wait eagerly for our adoption as children, the redemption of our bodies."

(Romans 8:22-23)

In our quest for the meaning of health, healing and wholeness, we heard the groaning of creation in various parts of the world. We also noted the 'birth' and 'growing pains' of programmes that demonstrate what it means to be healing communities. Health, healing and wholeness is inextricably linked to the socio-economic, cultural, spiritual and political realities of society.

There are special problems unique to countries which are moving toward industrialization and to those with full industrialization. Yet both are linked in an interdependent way. Violation and destruction of the environment in one part of the world impacts the ozone layer which covers all our world.

Pressure to meet the demands for goods of the Northern hemisphere lure countries of the South to expand cash crops and production of goods for export which can reduce their production of essential food and basic commodities at home.

Political and economic policies and the ability of rich countries to disrupt the daily lives of people elsewhere through direct or indirect supply of weapons and the means of warfare affect the health of many.

The demand that international debts be paid cripples the economies of debtor nations. The tragedy worsened because often the projects for which the debt was created did little to enhance the lives of the people of that country.

The creditor nations themselves are also harmed since the nations who must pay are left without the resources to buy the products of the first.

All of these issues impact health and wholeness and their solution may need to be found in the realm of politics. Christians recognize that the actions of governments and transnational corporations, in a quest for power and wealth, interfere with the Christian quest for health, healing and wholeness.

The Realities in 'Developing' Regions

In Asia, Africa, the Pacific and Latin America, the majority of people are poor in the midst of the abundance of their resources. This phenomenon is brought about by the concentration of power among the few who own and control the means of production such as land, capital, machines, and even the labour force of people who work for them, who in the majority of instances are paid cheaply. These few have international linkages with other business corporations as 'joint ventures' with transnational corporations or as front persons for such businesses. The 65-75% of the people who live below the poverty line are victims, having little access to services like health, education, housing, land, food and stable jobs.

In most countries where the majority are poor, repressive governments are installed by those who have interests to protect. A semblance of democracy through elections often takes place, but ultimately important decisions are made by those with power and affluence. Their power allows them to be elected repeatedly. When people become aware of injustices, their protests are met with apathy or violence.

It is these poor people who often get sick of communicable but preventable diseases. In many instances they have multiple diseases so that even if one disease is cured, another illness may finally claim the person's life.

Children are the most vulnerable group. If malnutrition in early life does not kill them, it will retard their physical and mental growth and development. In Brazil, for example, 6 million of the 10 million mentally ill are children, and 500.000 children die of malnutrition every year. Eighty five percent of the 450 million people in the world who suffer from disability come from developing countries, which receive only 2% of the resources to treat and care for disabilities.

Too sick, too late (TSTL) was the blanket name given by clinic doctors to diseases of the rural African child, and for many children of the poor for that matter. This is because of structures of injustice that hinder optimum growth and development, starting from the mother's womb. Because it is also very expensive to die, many of the poor are not even given a decent burial.

Worst of all, poor nations become the easy victim of inappropriate technology. Medicines declared as harmful in the country of origin are shipped to developing nations where governmental policies are very lax. Not only medicines but other harmful substances find their way into agriculture (pesticides and inorganic fertilizers), food habits and life styles of people (cigarettes and addicting drugs) and the environment (toxic wastes and nuclear tests).

In the Marshall Islands where 66 H-bomb testings were carried out, people still suffer from the long-term effects of radiation such as thyroid cancer, leukemia, deformed babies. Many had to relocate to safer but much less fruitful habitations as their islands became contaminated. Thus they have become dependent for their survival on outside help, exchanging sovereignty for money. Healthy eating habits have been replaced by the unhealthy consumption of canned and 'junk' food, resulting in higher incidence of obesity, diabetes and hypertension. Missiles fired from California land regularly on their target at the Kwajalein atoll. Eight thousand inhabitants of that atoll are now crowded on to a small island a fews miles away, creating a crowded slum in the vast expanse of the Pacific.

In certain countries where conscientized people are struggling for self-reliance and self-determination, oppressive colonial and neocolonial powers protect their interests through state terrorism which includes total war at the grassroot level (low-intensity conflict), torture and imprisonment and other forms of human rights violations. Deaths due to armed conflicts and other forms of political violence have escalated in the 1980s.

The Realities in 'Developed' Regions

These regions are highly industrialized and are the power centres in the world today because of their accumulated wealth. In these regions the values of individualism and materialism are deeply entrenched in the social institutions. Those who cannot 'make it' in the competitive society are the poor-especially the victims of racial discrimination and the marginalized drifters who resort to drugs and alcohol to escape from their loneliness and emptiness.

In North America, people are identified by the work they do. So when they stop working, usually at 65, people often find themselves to be useless. They suffer from depression as their living standards drop, sometimes to the point of poverty. Because people have been having smaller families, and because children are no longer expected to care for their parents, many of the elderly live alone.

In North America 50% of today's marriages end in divorce. There is increasing evidence of violence within families in the form of physical and mental/emotional abuse, often as a result of drug and alcohol use.

Industrialized surroundings are full of various stresses. At the North-East Asia Consultation it was reported that in Japan 90% of the male and 45% of the female adults are more or less alcoholic drinkers, and 2 million of them are presumed to be alcohol-dependent.

In both Europe and North America, health services, while generally of a comparatively high standard, are often focused narrowly on the individual patient, excluding his/her family and environment, and often just as narrowly on that part of his/her body which is ailing. This reflects a tendency in society as a whole to individualism and compartmentalization of knowledge and away from a more wholistic view. The trend is away from strong family ties and from close-knit communities which can supply people with support needed, especially in times of trouble.

In Australia, the aborigines fear 'assimilation'. Their culture is less individualistic, less success-oriented, less competitive. For instance, they do not give much importance to houses, and they would much prefer to be treated for illness in the community than be brought to a hospital.

Among Native Americans, a feeling of powerlessness is created by a public school system that often alienates their children from their own language and culture. When they grow up and find it hard to get a job, apathy, alcohol abuse and violence may be their response. Strong extended families and kinship ties are valued in their culture, something European Americans lack. Wholeness has always been central to the Native Americans. Birth and death are natural part of the life cycle. Insensitiveness to cultural differences may explain some of the mistrust they have towards government services.

In Socialist countries where basic needs are to be provided by the state, the need for caring communities from the perspective of the Gospel mandate becomes relevant. In Czechoslovakia, where there is strong pressure to accept atheistic materialism, spiritual emptiness vitiates against even the efforts of the state to provide better health care. People have come to expect that the state must provide everything—even health, which is claimed as a matter of right. So one tends to neglect the discipline of self-care and is unable to cope with suffering and the threat of dying.

New forms of illness develop as industrialization progresses. In Hong Kong children are no longer dying from communicable diseases but injury, poisoning and cancer. Strong pressure to compete, even at a young age, generates a lot of stress and frustration to those who cannot make it. Rejection from parents drive these children to live in bars and to a life of peddling, petty thieving, heroin addiction, unwanted pregnancy and other problems.

Polluting industries have caused lung diseases like emphysema, cancer, minomata disease or mercury poisoning and other pollution-related illness. When hard evidence was noted on the effect of pollution on the populations of industrialized countries, efforts were made to export polluting industries to 'developing countries'.

IV. ISSUES AND CHALLENGES FOR THE CHURCHES' INVOLVEMENT IN HEALTH, HEALING AND WHOLENESS

a) The congregation has a healing function
   * praying for the sick
   * confession and forgiveness
   * laying on of hands

* anointing with oil
* Holy Communion
* using creative healing liturgies
* supporting those who are committed to the healing task
* training ground for healers
* using the gifts of charisma

As a healing community the congregation unites forces with those of God and seeks to heal relationships among persons and the entire creation.

b) The congregation is a caring community

Within and outside the fellowship of the congregation are people longing for mutual caring and solidarity. They are the sick, lonely, handicapped, oppressed, marginalized and those with specific problems such as divorce, unemployment, pregnancy, etc.

c) The congregation is an ideal place for teaching

The important features of its teaching functions are:

* Bible study on Health, Healing and Wholeness
* Practical health education
* Ethical questions
* Personal Responsibility for Health
  - adoption of healthy life style
  - stewardship of the body
  - need for rest and recreation

d) The congregation acts as advocate for Justice, Peace and Integrity of Creation.

As advocates, the congregation takes the healing ministry into the political, social and economic arenas, speaking out against oppression, repression, racism and injustice.

* supporting oppressed people's struggle for liberation
* joining others of goodwill to participate in the process of growing together in social awareness
* creating public opinion in support of the struggle for justice in health

The message of liberation is integrated into the life of the Church. Participating with the people in the building of a just social order leads us to the way of the reign of God.

In working for a just social order as it relates to Health, Healing and Wholeness, the development of ethical standards are suggested in order to: Protect individuals and communities;

the environment — so that land, water, atmosphere and other forms of creation are not rendered useless or harmful to humankind.

e) The congregation is challenged to continue to provide support services and to promote Primary Health Care.

f) The congregation is challenged to recognise, support and cooperate with other partners in liberational healing such as:
   * family
   * health professionals
   * integrated healers
   * other agencies and communities
   * other faith groups

V. EMERGING ISSUES

Interpretation of the Gospel in the Theology of Health, Healing and Wholeness

The theology of health, healing and wholeness is a challenge and protest against those who live by the norms of accumulation of possessions for individual gain, unjust and merciless exercise of power and spirituality, for convenience and justification of life style.

The theology of health, healing and wholeness calls for cultivation of Gospel spirituality that sustains our option for the poor, opens us to participate in working for the liberation of the poor and accompanying them in their struggle.

The theology of health, healing and wholeness calls Christians to point to the signs of the Kingdom which are:

— commitment to the Gospel value;

— empowering the 'wounded healer' to carry out the task of developing healing and caring communities.

The invitation to the Kingdom is for all. But because of the demand of the Kingdom, the Gospel values have become bad news for the rich. How can a 'metanoia' conversion happen so that all of God's people will truly work together to become healing and building communities which are signs of God's Kingdom? What are the implications of the Gospel for the poor themselves?

Searching questions already addressed during the 1981 Central Committee meeting are still relevant today:

— Are we and our churches such healing communities?
— Are we really engaging ourselves in God's controversy with those who spread sickness around?
— Are we enabling our sick people and societies to diagnose their true sickness and find the resources for healing?
— Are we prepared to place ourselves beside the sick, the deprived, the oppressed with the healing power of God?
— Are we ready to join our Lord in His self-giving struggle with evil even to the Cross in order that healing, reconciliation, and wholeness may become manifest in a world which is sick unto death?

Dialogue

After all the consultations that took place, there is still little dialogue between medical professionals and theologians and pastors. The words used by theologians are not easily recognized or understood by physicians and vice versa. According to James McGilvray, this "may be because of the use of theological terms which are not to be found in the medical vocabulary, and it is difficult in the medical realm to find words analogous to the sequence, sin-guilt-repentance-forgiveness, all of which are related to the Christian common anthropology so that it is questionable whether the medical scientists and the theologians/ pastors are really looking at the same person." He continues to state that: "While the churches' pronouncement on medical-ethical issues loses much of its force and credibility through lack of unanimity within the universal church, it can and should provide a whole picture of life and its incarnational meaning by revealing the interdependence of the separate pieces. Unlike technology it looks upon the far larger scene in which the Gospel offers a meaningful whole. Perhaps its greatest contribution is to be with the professional who has his doubts, and with the patient in his pain, in order that both may relate their doubts and fears to the wide dimension of God's love. While wholeness may not be achieved in this life, the signs which point to it are inherent in the Gospel and provide a means whereby the issues can be identified and evaluated before decisions are made.

"As for the CMC, the dilemma presented by the galloping pace of technology is that while medicine continues to produce miracles for the few, but which are unavailable for the majority, how can one reconcile this with the promotion of primary health

care? This raises the question of how much health is good for one — or at least adequate, while developing countries are assisted with facilities that will enable them to catch up. Is my health more important than my neighbour's?"

Building Caring Communities

"It is clear to us that care of those who are sick or suffering is not a matter for just the doctor alone, but for everyone connected with the person. What is needed is a willingness on the part of all of us to enter into a deeper relationship, to talk and take counsel together, from which we can draw strength — the sense of bearing one another's burdens," one group report in Budapest stated.

It is clear from our theological and sociological reflections that we need to build caring communities. People are lonely, empty and feel alienated because of the growing individualism and materialism, not only from well-developed countries but also from lesser-developed countries to which these values have been exported.

The church is challenged to attack the issues of individualism and materialism in study groups and to build healing communities, not only among themselves but also outside their congregations, taking always the preferential option to serve the least of our brothers and sisters.

VI. VISION AND HOPE

The vision of the Church is a society where individuals live in harmony with each other, nature and God, fully participating unselfishly in meeting their own needs and those of others. Such a society accepts and rejoices at the unique and special gifts of each person. It utilizes God's gifts prudently, harnessing technology to enhance human life and protect the natural environment.

The Church can teach its members to care for each other, to confess their sins and brokenness, to nurture the unique contribution each can make, and to model for the world the health, healing and wholeness which is the promise of God. Theological reflection should now translate into action and the Christian Medical Commission of the World Council of Churches feels that the time is right to shift the emphasis from enquiry into action. Programmes will be developed to discover and share models other than medical of the church at work in healing, to

facilitate and encourage local churches to be involved in different forms of healing, and to evaluate and document the results.

As we embark on this new emphasis, we enlist the help of all who read this paper and pray for the guidance of God through the Holy Spirit.

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